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ABSTRACT

This guide on counseling abused children was written to help counselors meet the needs of children and adolescents and to provide ways of working with the child's family. Chapter 1 presents an overview of child maltreatment by identifying types of maltreatment (neglect, physical abuse, sexual abuse and exploitation, and emotional abuse or neglect) and discussing concerns for the counselor. Chapter 2 describes approaches a counselor may use to identify and assess child maltreatment, including interviewing children, adolescents, and parents; identifying signs of maltreatment; recognizing parental indicators of the potential for maltreatment; and recognizing interactional indicators. Chapter 3 concerns reporting maltreatment and protecting the child. This chapter addresses the issues of confidentiality and liability and explains the investigation that may take place after a report is made. The fourth chapter discusses a team approach to counseling abused children and describes a comprehensive approach to helping families. Chapter 5 discusses counseling the individual child, chapter 6 describes counseling abused children in groups, and chapter 7 concerns counseling abusive parents. References and a list of resources for counselors are included. (NB)

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COUNSELING ABUSED CHILDREN

Emily Jean McFadden

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ABOUT THE AUTHOR

Emily Jean McFadden, M.S.W., A.C.S.W., is associate professor of social work at Eastern Michigan University in Ypsilanti, Michigan, and associate director of national foster care education projects at Eastern Michigan's Institute for the Study of Children and Families. Her area of expertise is the recognition, intervention and prevention of child abuse in foster homes.

Ms. McFadden has had extensive experience as a counseling practitioner in children's protective services, foster care, child guidance clinics, and private family practice. She has also served frequently as a consultant in child abuse cases.

An active speaker and writer, Ms. McFadden has delivered hundreds of workshops on foster care and child abuse that have reached thousands of child care professionals around the world. Recently, she presented seminars in New Zealand for the Department of Social Welfare, and a professional paper in Sydney, Australia, for the Sixth Annual International Child Abuse Conference.

PREFACE

Counseling abused children and their families is not an easy task. It challenges our professional competence, and it challenges our notions about ourselves, our own parents and our children.

After the "discovery" of the Battered Child Syndrome in the Sixties, the initial outcry of public indignation was to punish these terrible people who harmed their children. Some people still feel this way. As counselors we may be aware, at times, of residual punitive feelings towards our clients and need to deal promptly with such feelings. However, today the major risk is not from public demand to punish maltreating parents. Rather, it comes from a naive faith in the merits of "counseling." Lay persons, judges, child protection staff, foster parents, school personnel--almost anyone who has thought about the problem of child maltreatment--believe that somehow "counseling" will remediate the problems of a family, decrease angry outbursts, control inappropriate sexual attractions, lift depression, instill moral controls, and guarantee the safety of children.

That is a tall order for the counselor, and one that is difficult if not impossible to fulfill. If we are to avoid fantasies of omnipotence and provide service on a realistic basis, we are wise to know our own limitations and to educate the public on what we can and cannot do.

We cannot predict human behavior. We have no crystal balls to tell us that this child will never again provoke a parent, or this parent won't drink too much and lose control. We can make knowledgeable assessments of situations, but we can never guarantee the safety of a child.

We cannot undo the long-term effects of poverty, oppression, racism, unemployment and other social ills. We can work collectively for social justice and help to empower families, but "counseling" is neither a substitute for empowerment nor a solution to social ills.

As counselors we cannot control the large systems which impact on children and families. We can make informed recommendations to judges, child protection staff or schools, but we must realize that the systems set up to safeguard children are fallible and need close monitoring. Sometimes we must fight to protect our clients from the systems set up to protect them.

We cannot cling to our traditional standards of confidentiality when it comes to the urgent business of protecting children. We must also learn to work with other professionals, share information and coordinate activities for the good of the children. This may mean giving away some of our own power, or learning the complex jargon of another profession for the purpose of improved communication and case planning.

Even if we thoroughly know our own limitations and acknowledge that the knowledge base is imperfect and evolving, we still feel a great responsibility. There is a nagging little fear lurking on the edges of our consciousness that if we make a mistake, a child will suffer more.

In the privacy of our counseling office or, more likely, in our car en route to the child's school or the family's home, we think about the children and wonder if we are adequate to fill the deficits in the child's life, or undo years of trauma. Before we fall asleep at night, we offer a quick prayer that all the children will be safe and the families healed.

Counseling Abused Children is based on the assumption that counseling is a limited intervention. It is not a panacea nor can it protect children. There are many interventions, such as the provision of concrete resources or use of parent aides and homemakers, which are effective in the treatment of child abuse and neglect. There are many situations in which the standard tools of counseling, such as expressing feelings or developing insight, are almost irrelevant in helping maltreating families.

Yet we do know that certain techniques for working with groups and individuals are helpful under certain circumstances. This monograph will attempt to acquaint the counselor with the salient issues in child abuse and neglect situations and with some helpful strategies for working with them.

There are many therapeutic approaches for working with abusive or neglectful parents. Unfortunately, the same attention has not been paid to the needs of the maltreated child. Thus, this guide begins with a focus on counseling the child. A thorough consideration of the developmental needs of the child is followed by a discussion of the needs of the parents in a counseling situation, as the most profound need of the child is for the parents. The old solution of placing the child in foster care has been found to be a temporary palliative which may provide immediate protection, but often creates long-term damage to the child. The risk of multiple placements which damage the child's sense of self, the possibility of the child drawing foster parents into established abuse patterns, and the trauma of separation from the biological parents must be considered carefully.

Counseling Abused Children is intended to help the counselor meet the needs of the children, whether they are toddlers or adolescents, and provide ways of working with the child's family, whether it is a biological, foster or adoptive family. The counselors who use this resource may work in schools, in social agencies, in treatment settings, or in community programs--wherever children are to be found and served. The exact role of the counselor will vary from setting to setting, but the focus of the counselor's concern will remain the same--helping abused children and their families.

Nothing in this monograph is intended to be definitive. It cannot replace professional training or supervision in the practitioner's preparation. Hopefully, it will serve as a guide and a reference. My wish is that it will strengthen the counselor who is undertaking a challenging role.

Emily Jean McFadden
Eastern Michigan University

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Counseling Abused Children is dedicated to Ara Cory, former director of the Grand Rapids Michigan Child Guidance Clinic, who helped me take the first steps, and to all the children and youth who have allowed me to enter into their lives and learn from them.

CHAPTER I

CHILD MALTREATMENT: AN OVERVIEW

Child maltreatment is not new. It has been around since the start of recorded history. The Bible tells us, "Withhold not correction from the child for if thou beatest them with the rod, he shall not die. Thou shalt beat him with the rod, and shalt deliver his soul from hell" (Proverbs 23: 13-14). Under Roman law, the father had absolute rights to discipline, sell, or kill a child. In the Middle Ages, mentally ill children were burned at the stake as witches. In both the Western and non-Western worlds, children were used sexually by their families or wealthy persons who bought or borrowed them for purposes of exploitation. The novels of Charles Dickens illustrate vividly the indignities to which children were subjected in the Victorian Era.

What has changed is the societal expectation for parents not to harm their children. Throughout history, most parents have offered "good enough" parenting for the children to survive and grow and continue the human race. Despite the differences in cultural expectations, or differences in religious or moral values about childrearing, the deliberate harming of children has never been acceptable to the vast majority of members of any given society. The family has historically been viewed as the repository of authority for child rearing. The state has been reluctant to intervene in the province of the family. Many legal principles are based on the assumptions of preserving family integrity and protecting the family from intrusions by the state.

Relatively recent developments have caused a shift in societal attitudes toward children. The work of psychologists and theorists in child development has established childhood as a critical time for the development of character and personality. The earlier interpretations of children's willfulness and stubbornness, with a consequent need for harsh discipline, have begun to give way to an emphasis on the child's need for tenderness and love. Although whipping and flogging of children is now generally considered harmful to children in the United States, there still remains a deeply embedded norm that it is acceptable for parents to hit or spank children for disciplinary purposes. Strauss and Gelles (1980) found that more than 90 percent of American children had been hit at least once by their parents.

Although the roots of the current child welfare system are in the nineteenth and early twentieth century, the current understanding of child maltreatment did not come into clear public focus until the Sixties. Earlier in this century there was legislation allowing protective societies to investigate child maltreatment and petition courts for the removal of a child, if necessary, on the grounds of neglect, dependency or delinquency. However, the new era was a result of a technological advance in pediatric radiology which enabled pediatricians to detect healing fractures by x-ray. Prior to the discovery of the Battered Child Syndrome by Helfer and Kempe, first announced at a symposium of the American Pediatric Society in 1961, medical personnel tended to utilize denial and believe the parents' stories of the child falling from a high chair or rolling off the sofa when a child with multiple fractures was presented at the emergency room.

Within the next few years after the documentation of the Battered Child Syndrome, all 50 states passed legislation requiring physicians and others to report cases in which they suspected physical injury of children had been willfully inflicted by parents and other caregivers (Giovannoni & Becerra, 1979). The advent of Parents Anonymous, a self-help group for parents with a child abuse problem, strengthened the public focus on child maltreatment. Through public testimony to the Congress, and appearances on talk shows, Parents Anonymous members such as Jolly K., the founder, spoke eloquently of the parents' need for help. In telling stories of their childhoods, the Parents Anonymous members gained sympathy from professionals and lay persons, as the understanding developed that many abusive parents had suffered maltreatment as children and were inadvertently continuing a destructive pattern.

Despite the increased public understanding of child maltreatment, there are diverse societal attitudes and reactions to the problem. A conservative political swing in the early Eighties reinforced assumptions that the state should not meddle in private family matters. A religious conservativism in many quarters underscored the old biblical assumptions about original sin and "spare the rod, spoil the child." In a culturally diverse and pluralistic society, there are many different norms and standards for parenting. "It is increasingly agreed in the child welfare literature that Black and American Indian children have been removed from their homes needlessly because of the failure of the workers to recognize cultural differences in parenting and the amount of care given by non-nuclear, including single parent and extended families" (Stehno, 1982).

Professionals in the child abuse field now acknowledge that many of the interventions offered to help children can be damaging. The sexually abused girl who testifies against her father in court may be revictimized by the legal process. Children who run away from home to escape abuse sometimes are held in secure detention for their "protection." The battered child placed in a foster home may provoke his foster parents to abuse him (McFadden, 1984). We have entered a period of questioning earlier practices and attempting to develop new strategies to help families. Yet the achievements of the past decades remain. Every state has a legal definition of child maltreatment and a mechanism established to protect children.

Types of Maltreatment

Maltreated children may have many experiences in common. A common theme underlying most forms of maltreatment--physical abuse, neglect, or sexual abuse or exploitation--is that of emotional hurt. The child who is physically abused suffers emotionally from the inconsistent parenting and the fear of further retribution; the sexually abused child suffers from the emotional neglect which leaves her or him vulnerable to the advances of the perpetrator; and the neglected child suffers from the lack of attention to basic needs which creates anxiety or apathy about life in general. Generally speaking, children who have been maltreated exhibit a lack of basic trust. For them, there is not an orderliness or predictability to their universe. Rather, it is a frightening place with no clear rules. The world of the maltreated child is one in which the child has to assume too much responsibility for his own existence, or for the parental happiness in the home. It is the child's job to keep Mom or Dad happy, to console the sad parent, to please the parent by preparing food or cleaning the house, perhaps to hold the family together. It becomes the child's responsibility to figure out when to approach a parent or when to avoid potential wrath. All of this uncertainty takes a toll. The child never learns to ask for help, to get his or her own needs met, to trust in adult figures.

One general consequence of child maltreatment is developmental fixation or "freezing." Insulting or interrupting normal developmental sequences has a significant effect on the developmental process. Its effect may be permanent if it continues for a long period of time, or it may be temporary if interrupted and normal processes are allowed to catch up or take place (Helfer & Kempe, 1976).

Children who are neglected score significantly lower in general cognition tests, and their emotional and language development is behind. They have difficulties in balance, fine motor coordination and ability to play. Well over one-half of abused children will have significant neurodevelopment or psychological problems which need attention. Mental retardation, learning disorders, perceptual-motor dysfunction, cerebral palsy and impaired speech and language are among the most common developmental delays and deficits to be found (Martin, 1976).

Child maltreatment has been divided into a number of categories which are not mutually exclusive. The following types of maltreatment will be examined: neglect, physical abuse, sexual abuse and exploitation, and emotional abuse or neglect. Within each general category there are a number of sub-categories. The counselor will find that many of the specific types of maltreatment are overlapping.

Neglect

Neglect has been virtually ignored as a form of child maltreatment despite the fact it is reported to authorities more frequently and accounts for more deaths than physical abuse (Trainor, 1983). According to the 1981 statistics of the National Study on Child Neglect and Abuse Reporting, only four out of every 100 reported children experienced a type of major physical injury, whereas 60 out of every 100 experienced a type of physical neglect. Neglect was associated with 56 percent of child deaths reported in 1981 (American Humane, 1983). Although neglect may actually be more deadly to the child, it does not generate the same level of concern with professionals or the public as physical or sexual abuse which are more dramatic. Neglect appears to be directly related to poverty more frequently than either physical or sexual abuse. It is also becoming more difficult to deal with in an era of diminishing resources and cutbacks on programs for families. Neglect is difficult to document and difficult to prove.

Neglect includes a variety of types. All types of neglect, however, are essentially a failure by the parents to provide something which is needed for the child's healthy growth and development:

> Abandonment is typically defined as leaving a young child unattended or unsupervised for excessively long periods of time.

Lack of Supervision is a failure of the caretaker (generally the parent) to account adequately for the child's actions and whereabouts. Lack of supervision exists when a young child wanders into the streets or ingests poisonous substances.

Nutritional Neglect is a failure of the caretaker to provide sufficient quantities of food and failure to provide an acceptable quality of diet, that is, appropriate nutrients.

Medical Neglect is a failure of the caretaker to resolve medical and dental problems and other treatment needs.

Educational Neglect is a failure to provide for the child's educational development. The most often identified problem of educational neglect is "permitted chronic truancy."

Inappropriate or Insufficient Clothing is a failure by the caretakers to provide minimum quantity and quality of clothing to a child.

Shelter Neglect is a caretaker's failure to provide basic minimum standards of adequate shelter, for example, space, heat, indoor plumbing, electricity, structural adequacy and sanitation.

Hygiene Neglect is the caretaker's failure to properly clean the child, who may appear smelly or dirty.

Failure to Thrive is a special category of child neglect, more common among infants and young children, in which children fail to grow at normal anticipated rates. (Mayhall & Norgard, 1983)

Neglect is a result of a combination of factors. The parents may have grown up in a subculture of neglect in disorganized and chaotic households. The functioning of the parents may be impaired by psychosis, mental retardation, severe depression, alcoholism or substance abuse. The inability of the parents may be exacerbated by chronic poverty or unemployment, lack of resources and supports for parenting, lack of adequate housing, or a crisis event in the family's environment.

Some definitions of neglect are culturally bound. For example, some Native American children, growing up in a traditional way, lived in log cabins with dirt floors and no electricity or indoor plumbing. Depending on the sensitivity of child protection workers, some children remained in their homes because the situation was viewed as culturally appropriate, while in other cases it was viewed as shelter neglect and the children were removed. As a result of such discrimination against Native Americans, and the "cultural genocide" of the child welfare system against Indian children, the Indian Child Welfare Act was passed in 1978 removing Native

American children from the jurisdiction of state child protection systems and placing them under tribal jurisdiction.

The concept of neglect includes the assumption that some harm must befall the child as a result of the parent's failure to provide. For example, if a child appears to be dirty--and most if not all children get dirty at times--the duration of the dirtiness, and the possible threat to the child's health must be established before the condition of dirtiness would be considered neglect. Some typical examples of child neglect follow:

> Susan, age three, was hospitalized with severe burns about the mouth and in the digestive system from ingesting lye. She had been left alone by her mother, and the dangerous substance was left within easy reach. Susan was underweight for her age and had a number of skin conditions which appeared to be the result of a lack of hygiene. Susan's hair was matted, her skin was crusted with dirt and scabs, and she wore only a soiled diaper and a tattered T-shirt when the police found her.
>
> Ronnie, age seven, came to school infrequently. He smelled strongly of urine and was teased by the other children. He was not able to keep up with his school work and frequently fell asleep in class. He was in need of eyeglasses, but his parents did not follow through on school recommendations. He was in trouble for stealing lunches from the other children. In cold weather, he wore only a sweatshirt, no coat.

Physical Abuse

The causes of physical abuse are diverse. It occurs in this country in a culture which sanctions certain forms of violence (war, sports) and which permits physical punishment of children. Physical abuse has received a great deal of attention since the announcement of the Battered Child Syndrome by Helfer and Kempe. The greatest risk of physical abuse is to infants, as they cannot run away or ask for help. The popular notion of physical abuse is that it is something that happens when a parent goes out of control because of the incessant crying of an infant or small child. However, physical abuse occurs to children of all ages, and for a variety of reasons.

Physical abuse is usually defined as the intentional or nonaccidental inflicting of injury on a child by a caregiver. It manifests as bruises, welts, broken bones, burns, lacerations, or occasionally death. It may occur through hitting, striking, beating, kicking, biting, slapping or other forms of violence directed at a child. There are two major difficulties in determining if abuse has occurred. First, were the child's wounds inflicted or were they accidental? Children do fall down stairs and off of bicycles. Abused children have typically been taught or warned not to tell, so they will not necessarily reveal what has happened. Rather, they may cover the incident with a story of having been clumsy or having been in an accident. Second, there is a lack of agreement on what constitutes serious injury. From state to state, from county to county, there are differing operational definitions of what constitutes abuse. In some areas the presence of belt buckle or strap marks on a child's back would be viewed as evidence of a beating with an object, and would be therefore construed as abuse. In other areas, where severe corporal punishment is viewed as a necessary part of parenting, such injuries might not be construed as abuse, and a standard might prevail that the child must have deep tissue injury before the punishment would be considered abusive.

The physical abuse of adolescent children is not uncommon, yet it is not always correctly identified as abuse. Often it is first noticed when the youth "gets in trouble" by failing in school, running away, committing a delinquent act, or going to professionals for mental health concerns or a suicide attempt. Because adolescents are physically mature, and presumably old enough to escape dangerous situations, less emphasis is placed on protecting them. Because some adolescents are rebellious or defy parental authority, there is a tendency on the part of many adults to blame the youth for "provoking" the parent. Only recently have adolescents been recognized as needing protection from abuse and other maltreatment. The concerned professional must look beyond the presenting problem such as school attendance or acting out behavior and see the adolescent's vulnerability and cry for help (Ziefert, 1982).

Many if not most parents who abuse children have been reared in an environment in which some form of maltreatment occurred. The abusive parent may not have been the target child of abuse in his or her family of origin, but most likely has witnessed the use of violence with children. Typically, abusive parents have been deprived of nurturing and empathic parenting when they were small, and do not know how to empathize with the needs of their children. Their expectations of children are high or unrealistic, and their knowledge of child development minimal. Abusive parents have experienced a high degree of stress which may include health problems, conflicted nuclear family and extended family relationships, isolation, employment pressures, unemployment, or financial problems. Although a minority of abusive parents are substance abusers, for some the use of alcohol or other drugs functions as a disinhibitor of controls. Physical abuse occurs in all socioeconomic classes, but is correlated with the stresses of poverty. It often occurs in conjunction with a specific stressor or crisis event. In other instances, it appears to be a parent's attempt to handle anxiety or release internal depression with an angry external act. A projection phenomenon may occur, in which the parent perceives the child as his or her own hostile, critical, unloving parent. When viewed from a family systems perspective, the abusive behavior has a function in maintaining the equilibrium of the family system. Some typical examples of physical abuse follow:

> Shana, age 15 months, is toddling around, "getting into everything." Both of her parents work and feel very pressured by their hectic schedules. Shana is not getting much attention or supervision from her exhausted parents. She is too young to have learned limits in what she can touch and can't touch. She is also sickly and whiny. Her parents gradually escalate from grabbing her and spanking her hand to shaking and then hitting her. Her crying exacerbates the tension in the home. Father shakes her, then loses control completely, throwing her against the wall.
>
> Andy, age 15, has been severely disciplined all his life by both parents, who believe in using the belt for "whoppings." He has adapted fairly well and learned to avoid his parents when they are under stress. He knows when to take care of his parents and when to make himself scarce. The incidents of severe corporal punishment decreased until Andy became an adolescent. As his parents began to fear losing control, they became more critical of Andy and his friends. When Andy verbally defied his mother for the first time, his father punched him in the jaw, breaking several bones in Andy's face.

Sexual Abuse and Exploitation

The sexual misuse of children includes incest, pedophilia, child prostitution, and child pornography. During the past decade, the reported rates of sexual abuse have skyrocketed, and the media have helped to bring "secret matters" into the open. The popular stereotypes of "stranger danger" have given way to a realization that incest does occur. The stereotype of incest between a physically mature adolescent female and her father or stepfather has been replaced by the knowledge that even young children are incestually misused, that boys as well as girls are victims, and that perpetrators may be female as well as male.

Although there are similarities between physical and sexual abuse (family problems, patterns transmitted over time and between generations), there are many differences. According to Finkelhor (1979), these differences are critical and must be recognized:

- Sexual and physical abuse do not occur simultaneously.
- The trauma of children's sexual abuse is primarily psychological, not physical.
- The motivations behind the two types of abuse are different. Some sexual abuse of children is like rape and expresses a hostile, coercive or sadistic impulse toward the child. Other sexual abuse may emerge from a desire for sexual gratification or sexual assertion.
- Social attitudes towards these two kinds of abuse are different. In overt ideology our society is much more intolerant of behavior resembling sexual abuse.
- The children most vulnerable to sexual abuse are preadolescents, whereas those most vulnerable to physical abuse are young children under six.

Current child protection legislation has been expanded in all 50 states to protect children from sexual abuse. States also have criminal codes which typically offer a tiered structure of offenses, ranging from the least intrusive (exhibitionism) to the most intrusive (rape or penetration).

The following examples illustrate the diversity of child sexual abuse cases:

> Larry, age seven, came to the attention of school social workers because of his disturbed classroom behavior. He indicated that he was very afraid of the dark and had to sleep with his mother each night. He also expressed somatic concerns and said his mother had to

> give him frequent enemas. Larry's mother was a single parent who had been abandoned years ago by his father. Since that time there had been men in and out of her life, but no consistent figure. The school social worker did not suspect sexual abuse by the mother, but did pick up signs in Larry's play that he might have been anally penetrated by a male visitor of his mother's. During a subsequent investigation Larry also revealed additional sexual contact by his mother, including genital stimulation and oral genital sex.
>
> Jill, age three, revealed in doll play at her Head Start class that "The Daddy doll kisses the little girl's pee pee." Her teacher had noted primarily that Jill was a timid and withdrawn child who didn't ask for any attention.
>
> Kenny, age 12, was part of a child pornography ring. He had been seduced at age nine by a neighbor who had shown the fatherless boy attention. He earned expensive presents by participating in the pictures and finding other boys for the "club." His mother had never questioned his frequent absences or the source of his expensive gifts.
>
> Lori, age 15, exhibited a sudden drop in grades in school and became depressed, apathetic and withdrawn. Her friends brought her to the school counselor because they were afraid she was suicidal. After several sessions she revealed that her parents were divorcing and that her mother had left home. Her father had been coming into her bedroom at night and asking Lori to "keep him happy" by performing oral sex.

Stovall's definition of child sexual abuse is comprehensive and focuses on the effect of the abuse on the child, as well as on the motivation by the adult: "Child sexual abuse is the adult (or older child) exploitation of the normal childhood development process, through the use of sexual activity. Examples of the types of sexual activity might include touching, kissing, fondling, manipulations of the genitals with the fingers, and actual sexual intercourse" (Stovall, 1981). Such a definition does not make a major distinction between a parental perpetrator or a pedophile stranger, but rather emphasizes the exploitation of the child's normal developmental need, such as the need for attention, affection and touch.

Densen-Gerber (1980) estimates that more than one-half million children were engaged in prostitution in the late Seventies, and that there were hundreds of magazines produced in the United States which depicted sexual acts among children and between children and adults. Sexual exploitation of children may be done by the parents or, when done by strangers, may be a result of serious parental neglect and lack of supervision.

There are many views of child sexual abuse. The earlier perception of the perpetrator as a psychopathic degenerate is not supported by research. The Freudian notion of the "seductive mother" is that the perpetrator's interest in children results from a disturbance in the mother-child relationship. The theory of sexual fixation is that sexual preoccupation with children results from an unusually pleasurable childhood sexual experience, so that the offender is conditioned to respond to that early childhood stimulus. The most current theory is that sexual offenses by adults are an expression of their diverse needs. For some perpetrators it is an attempt to attain closeness, for others sexual gratification (Finkelhor, 1979).

In examining the sexually abusive family we find a variety of factors. Such families typically have poor communication patterns, role confusion between adults and children, unclear generational boundaries, a high degree of stress, and poor self-esteem which makes it difficult to get one's needs met. One or both of the parents may have come from a family in which sexual abuse occurred.

In examining patterns of sexual abuse and exploitation, it is important to keep in mind that the knowledge base is changing rapidly. New research on the male victim has been requested by the National Center on Child Abuse and Neglect. In terms of the perpetrator, Finkelhor (1979) cautions "These generalizations (about perpetrators) must be taken with an appropriate dose of caution. What these men have in common may be more that they have been caught than that they had sex with children. The vast majority of offenders against children, the undetected ones, may be of an entirely different breed" (p. 22). McCarty (1986) found that female perpetrators consisted of both accomplices (who aided men in sexually abusing their children) and independent abusers, who had come from a background of sexual indiscretions, bad childhoods, unhappy marriages, and earlier sexual victimization.

Emotional Abuse or Neglect

What parent has not uttered harsh words to a child or ignored a child's plea for attention? How do we know whether a child is emotionally neglected or emotionally disturbed? How do we define the differences between inconsistent parenting, sporadic insensitivity, and actually damaging interactions--or lack of any interaction? Emotional abuse and neglect are elusive concepts and are the most difficult type of maltreatment to define or prove in court.

Emotional neglect generally implies a consistent indifference to the child's needs and covers a range of behavior. A temporarily depressed parent may fail to speak to the child or remove him from his crib, or the flagrantly psychotic parent may withdraw into a world of hallucination and illusion, unable to acknowledge the reality of the child's world or that the child actually exists.

Emotional abuse, on the other hand, implies an active rejection or persecution of the child by the parent. It is a deliberate action or series of statements resulting in harm to the child. Chronic verbal abuse erodes the child's self-esteem and programs self-fulfilling prophecies with negative scripts into the child's conscious and unconscious mind. In a sense, the parents actually teach a child how to be clumsy or stupid. The use of confinement or excessive punishment is also a form of emotional abuse. The child who is locked in the basement with a frightening dog is being emotionally abused. The child who is forced to stay in her room for days for "talking back" is emotionally abused.

Emotional neglect or abuse often accompanies the other forms of maltreatment. The child who is physically neglected by a sick or substance abusing parent is most likely not getting emotional needs met either. The child who becomes sexually exploited by a neighbor has first been made vulnerable to such advances by the parent's lack of supervision and inability to meet the child's normal needs for affection and attention.

One of the critical concepts for consideration of both physical and emotional abuse is that of bonding or attachment. When all goes well, an infant and caregiver can read each other's cues and respond to each other in a complex interactive mode involving vision, hearing, smell, touch and taste. When all does not go well, and the bonding is interrupted by premature birth, separation at critical stages, parental illness, or neurological deficits in the infant, the stage is set for diminished parent-child reciprocity. Issues of attachment come into play particularly with family arrangements where the child has not always been with the parent or is not biologically related. The mutual struggles of a child and stepparent, the anxious anticipation of an adoptive family, and the realignment of children's roles and responsibilities whenever a new child enters a foster family all illustrate some of the difficulties in forming new parent-child attachments. Children coming into foster homes may have serious attachment difficulties as a result of earlier broken placements and the trauma of separation from the biological family. Such children may panic when they begin to feel close to the foster family and run away or act out, "asking" to be sent away.

Emotional neglect or abuse can also occur in situations where the parent does not have adequate self boundaries and sees the child as an extension of the self. Such a child is not allowed to grow or individuate. If the parents' boundaries are quite blurred, it may lead to a form of sexual abuse in which stimulating the child is perceived as a form of self-gratification. Parent-child fusion often becomes obvious in educational neglect situations, where a parent is unwilling to let the child leave the home to attend school. Another type of emotional abuse involves projection of the parents' sexual concerns onto the child. This might include the adolescent girl habitually accused of "whoring around" by a father who is projecting his incestual urges, or the excessive punishment and humiliation of children who have been caught masturbating.

Like the other forms of maltreatment, emotional neglect and abuse of children are related to a history of deprivation in the parental background, and to stresses and lack of resources in the contemporary environment of the family. According to Powell (1983), the President's Commission on Mental Health states that minority children have been underserved by mental health systems. She states, "The deficit is in our capacity to face reality, and our will to change the reality of poverty--the most handicapping, disabling condition of childhood, with deplorable handicapping effects on six million non-white children in the U.S." (p. 7).

Although emotional neglect and abuse are difficult to define, difficult to "prove" in a court situation, and cover a wide range of behaviors, the following examples may clarify the concept for the practitioner:

> Sally had been rescued at the age of six from a raging house fire in which she saw her baby sister burn to death. For three years afterward she had screaming nightmares, was eneuretic, and became increasingly withdrawn in school. On investigation, it was discovered

> that her father "disciplined" her by burning things in front of her, or threatening to put burning paper in her hand.
>
> John was a shy and quiet adolescent who appeared to have no friends. When a sympathetic teacher attempted to engage him in afterschool activities, John's mother told the teacher that John wasn't allowed to have any social activities because of "what he might do." John was only allowed to leave the home to go to school and remained under his mother's constant supervision. It appeared that John's mother was fearful he might try to masturbate or engage in sexual activity if he was not under her constant supervision. John described how he had to sleep with his bedroom door open, and how his mother would stand outside the bathroom door saying, "I'm right here listening to you Johnny! Don't you try to play with yourself, or I'll know it and teach you some shame."
>
> A three-year-old girl did not know her name or the name of her little brother. She told the protective service worker that her name was "Little Cocksucker" and her little brother's name was "Little Fucker."

Many professionals are beginning to note the serious nature of emotional abuse or neglect. Garbarino (1979) asserts that mental injury to children is even more damaging than physical assault.

Concerns for the Counselor

An estimated 1,911,771 children were reported as abused or neglected in 1985. This translates into an estimated report rate of 30.3 per 1,000 children in the U.S. population (American Humane, 1986). The reported cases are only a part of all the cases that occur. In examining the societal context and wide range of types of child maltreatment, it is clear that the counselor's ability to identify maltreatment and help abused children and their families will depend in part on the community's response to the problem. The community perception of what maltreatment is and the provision of resources to help the child and his or her family will greatly affect the counselor's ability to provide service. One counselor noted that several children had been placed in foster care because their mother had left her abusive husband

and had no place to go with her children. The counselor quickly became involved in advocating for a domestic violence shelter. He realized that the mother was as much in need of protection as the children and that he could not counsel the parents on their care of the children as long as the wife was in danger from the husband. The developmental needs of the maltreated child are overwhelming and call for coordination of educational, medical and social/psychological services. The situation of the maltreating family is multifaceted and complex and may require a unique combination of social control limits, concrete resources such as food and housing, plus counseling or psychological services. Part of the counselor's role in helping the children is to apply specialized professional knowledge in such a way as to move the community ahead in the development of a greater range of resources for families.

CHAPTER 2

IDENTIFYING AND ASSESSING CHILD MALTREATMENT

Because the counselor is a professional who sees the child or parents privately and over time, the counselor is in a unique position to develop enough trust to enable the child or parents to ask for help. There are many ways in which clients ask for help, most of them indirect. The abused child may never state, "Please help me. I'm being hurt by my parents." The alert counselor will pick up many hints, many cues, many nonverbal ways the child will reveal the problems.

It is important to keep in mind that maltreated children usually do not wish to reveal what is going on at home. Unless the child is totally emotionally deprived, there has been adequate attachment to ensure that the child wants the parent to love him. Thus the child does not wish to betray the parent, or to risk losing the parent's love and approval. Inconsistent parenting produces children who are very needy of parental approval and who will move mountains in order to obtain crumbs of parental praise. Many children who are maltreated incorporate the parents' statements that they are "bad" children and that the abuse is their own fault. It is safer to believe that one's parents are right and that one is bad or naughty, than to consider the possibility that parents are wrong. As long as the child blames him/herself, he or she feels some measure of control over what is an unpredictable and distressing situation.

Additionally, children frequently will not verbally reveal maltreatment because of the cumulative effect of threats. Mama spanks Jamie with a brush, leaves a bruise and says, "You'd better not show anyone your butt, because if they saw that bruise the police would come and take you away." The worst fear of children is separation from their families. A father may tell his daughter, "Honey, as long as you're 'nice' to me like this, I won't have to leave home. If you stopped being nice, I'd have to leave and then the family would break up. You're keeping our family together, honey." In more extreme cases, the threats may be of bodily harm, not abandonment. A sexual abuse perpetrator picked up a little girl and hung her out the sixth story window. "Look down," he said. "If you ever tell anyone about our secret game, I'll drop you out this window."

Children who have been emotionally abused or neglected have great difficulty in believing that they are worthy enough or valuable enough for someone to care about their plight. They have no reason to trust the counselor with their concerns and secrets, unless the counselor has proven over time, through repeated testings, his or her dependability and interest in the child. Maltreated children often have deficits in language, and it is hypothesized that it is a result of learning that it is not safe to talk. Consequently, we cannot assume that children or adolescents will use verbal means to indicate their distress.

Interviewing Children

The sensitive counselor will let the child proceed at his or her own pace, even if the counselor feels pressed for time. If a child feels pressured, he or she will be likely to clam up. Rather than convey any sense of urgency, the counselor should express verbally and nonverbally the idea that the child is in a sanctuary in time and space, a place where there is no pressure, no rush or hurry.

Understanding the child's ambivalence about "telling," the counselor will refrain from direct probing questions and will utilize a variety of nonverbal approaches in communicating with the child or youth. Younger children will use doll play, colors, or toys to express their concerns. Older children respond well to being given a piece of paper as a "doodle pad." Much of a counselor's time will be spent in relaxed observation of the child, rather than in direct one-to-one interaction. In assessing a four-year-old boy who was suspected of being maltreated, the counselor used their second session together as an opportunity for observation:

> **Counselor:** Randy, remember that last time we agreed you could play with any toy you wanted to, and it would be ok with me?
>
> **Randy:** (Silently nods head.)
>
> **Counselor:** Randy, remember how this is a place where no one will make you do anything you don't want to do, and no one will hurt you?
>
> **Randy:** (Silently looks at floor, looks up at counselor out of the corner of his eye.)
>
> **Counselor:** You can pick any toy you want, and just play.
>
> **Randy:** (Quietly.) Just play?
>
> **Counselor:** (Nods his head.)

(Randy rams a toy car around listlessly, looking over his shoulder at the counselor, scanning the environment in a hypervigilant way.) The counselor noted the child's hypervigilant stance, his silence, the flatness of his affect, and his withdrawn posture. (Randy drops the car and picks up a teddy bear.)

Randy: Bad, you damn bad bear. (Randy hits the bear with his fist, then looks at counselor.)

Counselor: The bear got hit.

Randy: Yup. He's a bad boy. He got doo doo on the floor. (Slaps bear.) Bad. Bad boy, damn you to hell.

Counselor: Mmmmmm

Randy: I just gotta make you mind. (Throws bear face down on the floor.)

Counselor: Mmmmmm

Randy: Is this a bad bear?

Counselor: Looks like you think the bear was bad.

Randy: Yep, he didn't pick up his doo doo when he dropped it on the floor.

Counselor: What happens to bad bears?

Randy: Then the mommy bear has to scream and the daddy bear punches him.

The counselor did not question Randy directly, but rather observed and reflected back to Randy the content of his play. Randy was able to distance from his own anxiety and pain by talking about the bear rather than talking about himself and his family. The counselor did not try to force Randy to "tell" on his family. Rather he proceeded slowly, allowing trust to build and Randy's confidence to unfold.

Interviewing Adolescents

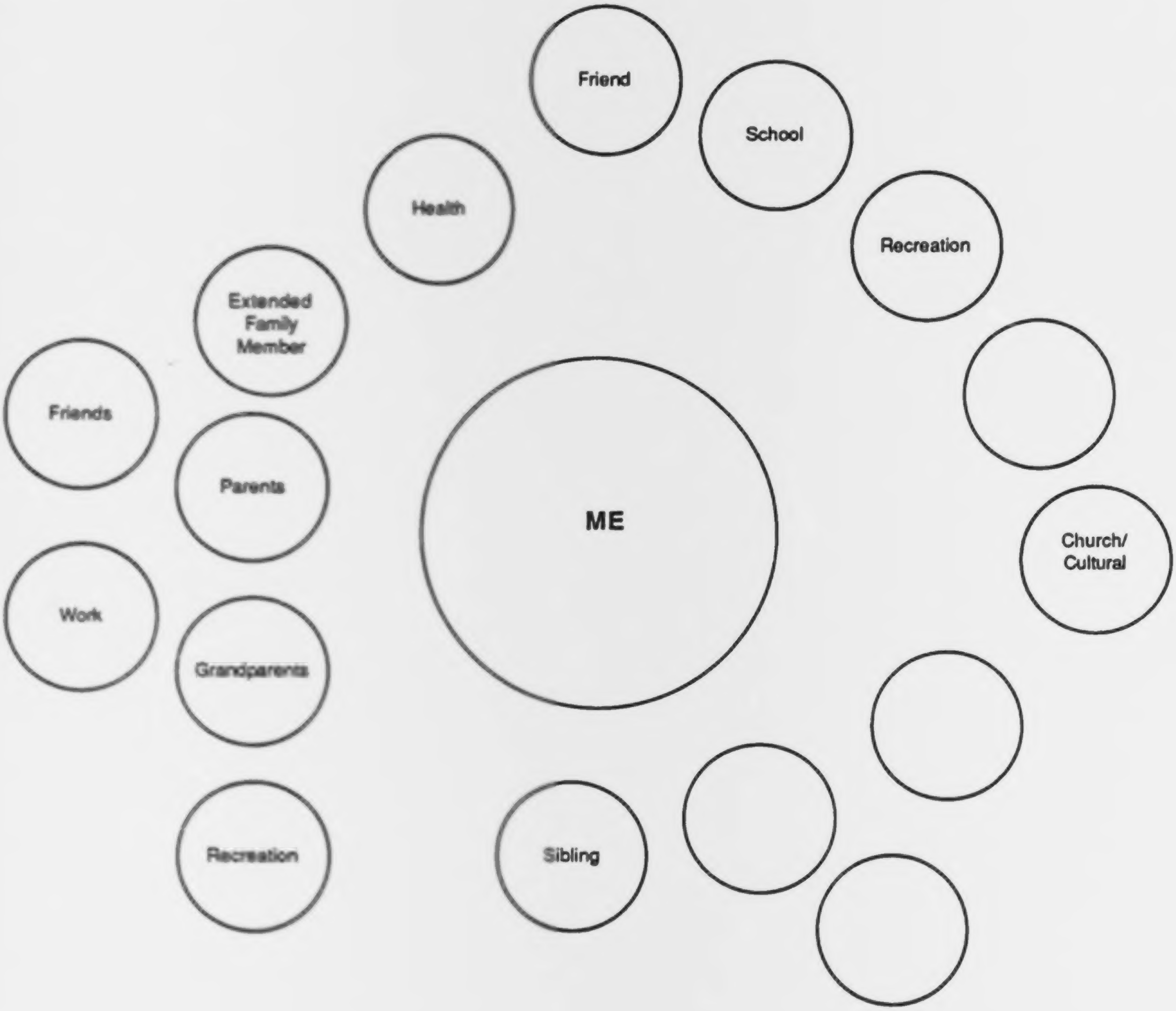
Normal adolescents are typically uncommunicative with the adult world, responding in monosyllables to adult queries. The adolescent subculture perpetuates generational boundaries by using slang as "in-group" language. By the time adolescent slang has been popularized to the point where adults understand it, adolescents develop a new set of terms, as incomprehensible to adults as the earlier terms had been.

Abused adolescents are often even more reluctant to reveal maltreatment to counselors than younger children, as they have made a realistic appraisal of the consequences of such revelations. They are understandably hesitant to involve themselves with adult representatives of authority such as police, court officers or child protection workers. At the same time, the positive side of their ambivalence is eager for help. The task of a counselor in working with adolescents is to facilitate the expression of both sides of the ambivalence, recognizing that the youth will find verbal communication difficult.

Providing the youth with an opportunity to work on an eco-map (Hartman, 1978; Ziefert, 1982) allows him or her to express concerns with paper and pencil in an objective, nonverbal manner. The counselor first explains that an eco-map is a diagram which creates a picture of the youth's life. It represents the youth's world, with school, home, friends, recreation, work, transportation, etc. depicted by circles on the map. The youth has an opportunity to show the type of connection with school, work, etc. by the kinds of connecting lines he or she draws on the map. A strong connection is portrayed by a heavy line, a weak or tenuous connection with a dotted line. A stressful connection is shown with a cross-hatched line.

________	strong connection
. . . .	weak connection
-/-/-/-/-/-/-	stressful connection

TEEN ECO-MAP


Friend
School
Health
Recreation
Extended Family Member
Friends
ME
Parents
Church/ Cultural
Work
Grandparents
Recreation
Sibling

Draw arrows to signify flow of energy, resources, etc. -----> ----->

Fill in connection where it exists.

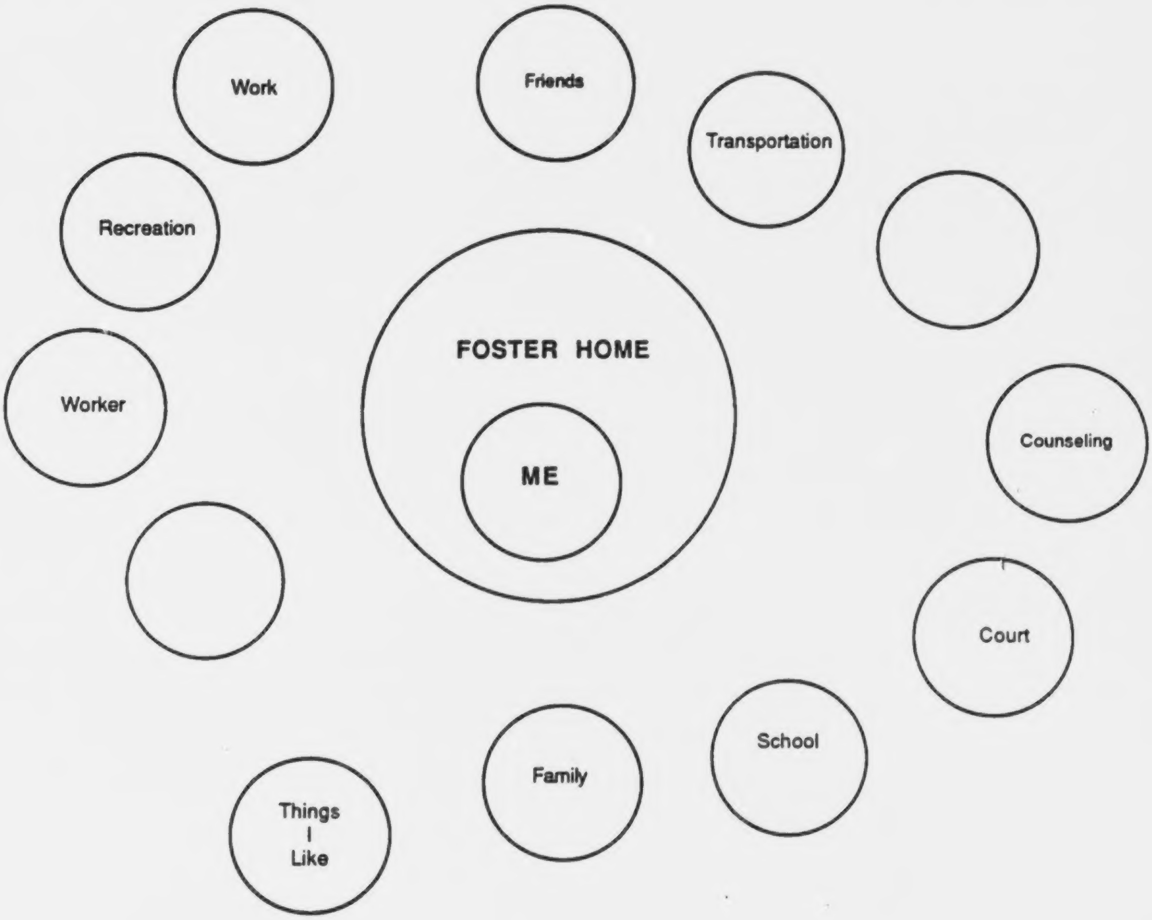
———————— strong connection

-+-+-+-+-+- stressful connection

---------------- tenuous connection

Adapted from eco-map developed by Dr. Ann Hartman.

TEEN ECO-MAP FOR YOUTH IN FOSTER HOME


Work
Friends
Transportation
Recreation
FOSTER HOME
ME
Worker
Counseling
Court
School
Family
Things
I
Like

Draw arrows to signify flow of energy, resources, etc. -----> ----->

Fill in connection where it exists.

________________ strong connection

-+-+-+-+-+-+- stressful connection

---------------- tenuous connection

Adapted from eco-map developed by Dr. Ann Hartman.

Counselor: Susan, here is an eco-map to help you take a look at some of the things going on in your life. It will be yours to keep and it is yours to work on. You've been telling me that there is a lot going on for you. This eco-map is a way for you to put down on paper some of the things that are confusing to you.

Susan: Okay.

Counselor: Here you are in the center circle. There is school in the circle over here. How would you like to show your connection to school. Is it strong, or weak or stressful?

Susan: Like that. (Draws a cross-hatched line.)

Counselor: Looks like you feel school is kind of stressful now.

Susan: Yup!

Counselor: How about transportation? Do you have ways of getting around?

Susan: (She silently draws a dotted line, shaking her head.)

Counselor: I see. Looks like a pretty weak connection.

Susan: My dad won't let me go anywhere.

Counselor: Mmmmm. What other connections do you have?

Susan: (She continues to draw silently, filling connections with all the circles on her eco-map.)

Counselor: When I look at your eco-map, Susan, I see a lot of stress lines and a few weak connections. I wonder if you're having a rough time right now.

Susan: (Tears begin to flow.) You don't know the whole story.

The counselor allowed Susan to take the lead in showing her life situation via the eco-map. She did not press Susan about her concerns, but rather followed the girl's lead, reflecting back what Susan had described nonverbally. Before Susan opens up completely to the counselor, she will have to be reassured of the counselor's caring and commitment to provide help. Susan may want assurances of secrecy and promises that the counselor will not notify the authorities. The counselor must be clear on legal responsibilities of reporting and not deceive Susan or make false promises. She can, however, provide assurances that she will stand by Susan through whatever may come next. The counselor should give Susan a realistic appraisal of the process they will go through.

Recognizing the sexual abuse of male youth can be particularly difficult for the counselor. Boys are reluctant to reveal sexual abuse because of fears that it is unmanly to be victimized. Boys equate passivity with homosexuality or femininity. Fearing that their masculinity will be questioned or challenged if they report molestation, most boys remain silent (Nasijleti, 1980). Sexually victimized boys will often defend against fears of being unmanly with a flurry of aggressive activity. Older youth may become perpetrators with younger children or learn martial arts as a form of self-defense. Often fear of reprisal keeps the boy from reporting while he is young. When he becomes taller and bigger in adolescence he may finally feel able to protect himself and be willing to discuss the victimization.

The author has found that providing information is very useful in encouraging boys to reveal sexual abuse:

> **Counselor:** You may have a friend who has been sexually abused who could use your help. I'll bet you didn't know that almost as many boys are sexually abused as girls are. But boys don't like to talk about it.
>
> **Ron:** Why not?
>
> **Counselor:** A lot of boys worry about two things--that if they have been sexually abused, it makes them like a girl or it makes them gay.
>
> **Ron:** Oh!
>
> **Counselor:** Actually, boys need to know two things. First, is that gender identity (that means knowing that you are a boy) is established before age three or four. And that never changes. Once you know you are a male, you are always a male. Sexual abuse doesn't change that.
>
> **Ron:** Hmmmm
>
> **Counselor:** And sexual abuse doesn't change your sexual orientation. Sexual orientation means whether you are heterosexual or homosexual. A boy who is sexually abused and felt like a heterosexual before the abuse is still a heterosexual after the abuse. Some boys worry because they respond physically to the sexual abuse. An erection is just an involuntary physical reaction. It doesn't mean that the boy is wanting to be sexually abused, or had changed his sexual orientation.
>
> **Ron:** You mean being sexually abused doesn't make you gay?

Counselor: No, but it can be an upsetting experience and it can help to talk about it.

Ron: Well, I do know someone who was sexually abused, and he might like to talk about it with someone.

Counselor: Okay.

Ron: It's me. I never thought I'd tell, but now it doesn't seem so hard.

Identifying Signs of Maltreatment

The counselor realizes that indicators of maltreatment do not exist in isolation but often cluster together. One indicator does not necessarily guarantee the occurrence of maltreatment, but configurations of indicators increase the likelihood of maltreatment.

Indicators of Neglect

- an infant or young child does not cry for help or attention; makes no sound, or makes a tiny sound like a kitten's meow
- dirty, unkempt appearance
- child inappropriately clad for weather
- lack of affect
- malnutrition, underweight
- child smells of urine, excrement, or severe body odor
- fatigue, apathy, listlessness
- untreated medical problems, frequent illness
- poor school attendance

All or any of the above indicators would tend to be chronic rather than situational. The child, over time, would display patterns of neglect.

Indicators of Physical Abuse

- aggressive behavior
- fearful of adults
- flinching when an adult approaches

- art work displays violence; adults loom as large, threatening figures, child figures are small and powerless
- preoccupation with themes of conflict
- unexplained bruises, welts, lacerations, broken bones, sprains, burns and other injuries
- hypervigilance, monitoring the behavior of adults
- "hyper" behavior
- obnoxious, provocative behavior
- bullying smaller children
- hiding, withdrawing from adults
- play demonstrates violence to dolls, animals
- the child is compliant, eager to please adults, seems to be "too good"

Indicators of Sexual Abuse

- genitals chafed, torn, bruised, irritated, itching
- eating disorders, gagging, anorexia, overeating, nausea, ulcers
- sleep disorders, nightmares
- constipation, fecal retention, fecal impaction
- urinary tract infections, venereal disease, genital discharge
- self-mutilation, disfigurement
- fearful of bathrooms, bedrooms, being alone with an adult
- fearful of same or opposite sex adult
- fearful of closeness, intimacy, touching
- difficulty in expressing feelings, low self-esteem, fears of separation and loss
- overly compliant
- excessive risk taking, suicidal thoughts or actions
- inappropriate sexualized behaviors: clinging, fondling, flirting, rubbing, public masturbation
- sexual themes in language or play
- sexual aggression to smaller children, toys, pets
- knowledge of sexual matters too advanced for age
- hints of secrets or secret games
- drawings are more precise in anatomical detail, sexual themes are evident

Indicators of Emotional Abuse or Neglect

- school problems, no energy available for learning
- social isolation, poor peer relationships
- inability to trust, ask adults for help
- aggressive, obnoxious or "hyper" behavior
- apathy, depression, suicidal thoughts or gestures
- statements about being worthless or "nobody"
- excessive nervous mannerisms such as twiddling, twitching, fidgeting, hairpulling, thumbsucking
- repetitive stereotypic motions such as rocking, banging
- frequent disappearances or runaway episodes
- substance abuse
- crying, sighing, clinging, weeping
- absence of affect and ability to communicate feelings
- self-mutilation, digging or picking at skin
- hoarding, gorging, or stealing food
- fears, anxieties and phobias

Remember, these are indicators that something is amiss. The presence of one indicator does not necessarily mean that maltreatment has occurred. The counselor looks rather for configurations of indicators. There may be considerable overlap between categories. The child who is sexually abused is probably also emotionally neglected by at least one parent. The child who is physically abused may be emotionally and verbally abused at times when the abusive parent is trying to bring the physical abuse under control. The child who is physically neglected is likely to be emotionally neglected also.

Interviewing the Parents

Although children give many behavioral and interactional cues that they have been maltreated, it is useful for the counselor to work with the parents in assessing the likelihood of abuse. Many parents want help and will respond quickly to the counselor's empathic approach. Other parents will present greater difficulty. It is important to keep in mind that the counselor's role is not that of an investigator, and that the purpose of the interview is to form a helping relationship, not to determine the nature and incidence of abuse. In the assessment process the counselor may suspect maltreatment and determine that reporting is necessary. But the counselor is looking beyond the narrow focus of detecting maltreatment. The counselor is trying to understand the nature of the child's family system, how it functions, and how it may be related to the problems which first brought the child to the counselor's attention.

In meeting with the parents it is helpful to keep in mind that many parents are frightened of the authority implied in the helping professional's position. If the counselor is part of a school, the parents may be anxious and uncomfortable about their own unhappy experiences in school 20 years ago. If the counselor is part of a mental health agency, the parents may be frightened of being thought "crazy." If the counselor is part of a social service agency, the parents may be bothered by memories of "the welfare" or "the people who took kids away." To allay the parents' anxiety, the counselor should quickly clarify his or her role and find out if the parents have ever seen a counselor before, or what their notions are about the operations of the counselor's organization or agency.

Rather than focus on the child's problems and needs, the counselor works on setting the parents at ease and showing concern for the parents' situation. Maltreating parents have emotional deficits resulting from the inadequate parenting they received and consequently have difficulty focusing on their children. In building a therapeutic alliance, it is important to offer the nurturance the parent needs, instead of focusing on the child's need for nurture.

In talking with the parents and learning their points of view, it is useful to explore the stresses of their current situation. Filling in an eco-map helps them to see the variety of stresses impacting on their lives, and the presence or lack of resources in their environment. As with the adolescent, the parents will often respond more favorably to nonintrusive paper and pencil techniques than to a series of questions.

After exploring the parents' world--the stresses, their points of view, their feelings, their concerns--the counselor is ready to move the focus of the interview to the child. This should evolve naturally from the parents' other concerns. The counselor is careful to phrase questions and statements so that they key into parental perceptions and concerns. The parent is "the expert" on this particular child, and the counselor is trying to understand the parents' point of view. Any impulse by the counselor to explain the child to the parents or defend the child should be promptly checked, as it would cut off the flow of information coming from the parents.

How does the parent see the child? Just how difficult is the child's behavior? Is this a critical child who is never satisfied? Does the parent sometimes feel frustrated or helpless? What does the parent expect that the child should be able to do at this stage of development? Does the child satisfy these expectations? How does the child "push the parent's buttons?" Does this child seem to defy parental control? Is there anything different or special about this child? Has the child always been like this? What was it like when the child was younger? How was it when the child was born? What had been the parents' hopes then? What is needed to improve the situation with the child now? Are there some particularly good qualities about the child?

After exploring the parents' perceptions of the child, the counselor moves to helping the parents explore their own childhood. How was their childhood like or different from their child's experience? What were their parents like? How were they disciplined? What was the best thing they remember from childhood?

During the interview, the counselor explores the parents' situation in order to build a helping relationship and to determine the problems and stresses affecting the family. Understanding the parental perceptions of the child aids the counselor in assessing the potential for maltreatment, keeping in mind the transactional nature of abuse.

Families who maltreat their children are like other families in some ways and are also unique. It is difficult to generalize about maltreating families. Some parents may be intellectually limited and relatively nonverbal, so they don't manage well in an interviewing situation. A few may be psychotic and in poor touch with the reality of their situations. Some may be fairly seriously character-disordered and try to con, play games or outsmart the counselor.

The majority of parents fall into one of two general categories regarding the maltreatment of their children. The first group would feel that there is nothing particularly wrong with the way they are raising their children. The counselor will hear such statements as, "My dad was a hard man but a good man. He used the belt on us when we got out of line, and we were pretty bad kids and needed that kind of discipline. I try to be strict like my folks because, after all, we needed that firm hand," or "Sure we like to have a few beers, and we move around a lot. It's hard to get a job nowadays. We were poor as kids and had a hard life, especially when Mama was drinkin', but there's no crime in being poor. I wish that school would get off our backs about Tanya." Although these parents may have been raised in a World of Abnormal Rearing (Helfer, 1975), they have identified with their parents and rationalized the maltreatment they may have received.

The other group of parents would also have experienced difficulties in their childhood with some form of maltreatment. However, they would have wanted to parent differently and to provide better care for their children than they had received. They are often horrified and guilty to see that they are repeating patterns from their childhood. This type of parent may actually ask for the counselor's help and reassurance. Most of the other parents will not ask for help as a typical "voluntary client" would. It is important to see both parents, as there is a tendency to underestimate the father's contribution to a situation of maltreatment.

Parental Indicators of the Potential for Maltreatment

Neglect

- extreme poverty or material deprivation
- high level of stress
- disorganization, chaos in lives
- little or no relationship with kinship networks or friends (Giovannoni & Becerra, 1979)
- apathetic-futile personality, emotional numbness
- impulse ridden, restless, rebellious
- mentally retarded
- reactive depression
- psychotic, bizarre behaviors, delusional systems, thought disturbances, hallucinations, severe anxiety, loss of contact
- substance abuse, alcoholism

Physical Abuse

- childhood history of abuse or emotional deprivation
- belief in severe corporal punishment as effective, right, or the will of God
- blames the child for family problems

- crisis events around the child's birth
- child separated from parent in early life, bonding disruptions
- child perceived as "weird," strange, bad, possessed, different
- child perceived to resemble someone the parent dislikes
- marital problems displaced on child
- isolation of parents from family, friends or supports
- unrealistic expectations of the child's developmental stage
- parental substance abuse
- blames the child for injuries to the child
- high degree of stress on the family
- difficulty in trusting, expressing feelings
- evidence of role reversal--parents expect the child to make them happy, to take excessive responsibility in the home
- low self-esteem, sense of self-worth

Sexual Abuse

- marital conflict, distance or disengagement
- childhood history of emotional deprivation and/or sexual misuse in the family of origin
- high degree of stress in family
- one parent absent a great deal, leaving other parent alone with the child
- one parent indifferent in supervision, other parent possessive and overprotective
- child may be perceived by a parent as "seductive," "slut," "nasty," etc.
- inability of parents to communicate needs and feelings
- role reversal, with child being expected to take care of a parent or keep a parent happy
- social isolation, or boundaries that are too open, with many people entering and exiting the living situation
- favoritism of a parent to a certain child

Emotional Abuse and Neglect

- parent is psychotic
- parent is substance abusing

- parent does not see child as an individual, but sees child as an extension of him or herself
- parent promotes or encourages severely dysfunctional behavior by the child
- high degree of tension in home, between parents
- parent significantly depressed
- excessive need for control by parents
- failure to set any limits or provide discipline
- inability to read a child's cues, provide warmth or attention
- parent's childhood was emotionally deprived
- parent verbalizes harsh criticisms, negative perceptions of child
- parents set up double binds for child in which he can't win or please parent
- parents acknowledge using cruel or bizarre punishments with child

Although it is possible for some of these factors to exist without abuse, the more indicators there are in a configuration, the more serious the situation may be.

Interactional Indicators

Whenever possible, counselors should attempt to see parents and children together to observe the family process. It is difficult at first to move out of an interviewing mode and into an observational mode, but it is well worth the time spent. By careful observation, the counselor can focus on a myriad of nonverbal interactions in the family system. For example, it is possible to observe which behaviors by the child seem to trigger parental response, the function the child serves to reduce marital conflict, or the parents' inconsistent patterns of reinforcement which contribute to the irritating behaviors by the child.

Most families can "put up a front" for a few minutes, but left to their own devices over a period of time will enact all the routinized family transactions which have led to the present dysfunction (Minuchin, 1978). The counselor's role can be to facilitate this enactment by giving the parents a task to perform with their children and observing how the parents handle it. The counselor may suggest that the parents take some time out to comfort a crying child, involve a child in a game, or explain something to a child. If the counselor wishes to know more about family control issues, he might ask the family to make a decision together concerning one of the children.

The counselor observes the family interaction quietly so as not to offer verbal or nonverbal reinforcement of any of the family process. The counselor notes who seems to be in charge of communication, whether a child has to look to a parent for permission to speak, how children trigger parents' reactions, etc. The counselor also notes nonverbal threatening gestures, affect and facial expressions. Some of the familial interaction indicators of maltreatment are as follows:

- A parent is very controlling of the child's behavior; the child appears fearful and glances at the parent for nonverbal permission to move or speak.
- One parent is excessively involved with a child, and the other parent appears totally indifferent or disengaged.
- Parents can set no limits, and children are totally out of control and disruptive.
- A child does something, a parent loses control and hits, verbally abuses, or otherwise overreacts in front of the counselor.

Summary

In attempting to identify and assess indicators of maltreatment, there are a number of approaches that may be used by the counselor. The most comprehensive assessment will be developed by using a combination of these techniques: working with the child individually, meeting with the parents, and observing the interactions of the family unit. If possible, it is helpful to see the family in their own home at least one time to get a sense of how the family behaves on their own turf, when they are not constrained by the strangeness of the counselor's office. The child is part of the family system, and abuse is a transactional process. In both assessment and treatment, the counselor views the child as part of the family, regardless of whether the child is a client as an individual or the whole family is the client.

There are three levels to the initial assessment process. First is to determine the needs of the child and family. Second is to determine if the potential for maltreatment exists, or if maltreatment has occurred. Third, if the potential for maltreatment is present, or the counselor has reason to believe it has already occurred, the counselor must make a decision about protecting the children and reporting the suspected abuse.

CHAPTER 3

REPORTING MALTREATMENT AND PROTECTING THE CHILD

Counselors who have reason to suspect that a child is being maltreated should report to the proper authorities. All states have child abuse reporting legislation which grants criminal and civil immunity to the person making the report (National Center on Child Abuse and Neglect, 1979). In most states school personnel, mental health personnel, medical personnel, and social services workers are required to report suspected maltreatment. Most counselors work in a school, mental health, medical or social service setting and would be likely to fall under mandatory reporting provisions. Counselors should be familiar with the child abuse reporting law of their state and should have the number and address of the department of social services, family and youth services or designated reporting point.

In order to report, the counselor does not need to be able to prove that maltreatment exists. However, she or he should have collected and analyzed all data available. A counselor in a school setting should check with the child's teachers (especially a gym teacher who might be more likely to observe marks and bruises) and the school nurse. Counselors in any setting should have explored with other staff, and discussed with protective services, how reporting should be carried out. A protocol or set of guidelines for reporting should be developed in any setting which serves children. To make a report, it is helpful if the counselor knows the following:

- names of the child and parents
- address
- age and sex of the child
- type and extent of the child's injuries or complaints
- evidence of prior injuries and complaints
- explanation given by child
- name and telephone of the reporter
- actions taken by the reporter (such as detaining the child, photographs)
- other pertinent information (Tower, 1984)

Additionally, the counselor will want to provide the following information:

- dates of contact with the child and family
- the counselor's role in working with the child and family
- indicators of maltreatment the counselor has noted in the child
- indicators the counselor has noted in the parents and in the family interactions
- the counselor's future role with the family if children's protective services becomes involved
- whether the counselor wishes to remain anonymous as the source of the report
- whether or not the counselor would be willing to go to court to testify on behalf of protecting the child

There are many difficult issues for counselors in the reporting of child maltreatment. They fear that reporting may jeopardize their relationship with the child and the family, and they may regret the suspension of confidentiality. Often counselors are annoyed because protective services doesn't get back to them with the results of the investigation or fails to view the matter as seriously as the counselor may. On the other hand, discussing the situation with the child protection expert can be a great relief. Even if the situation is not investigated, the protective services staff can provide support to the counselor.

There is some disagreement about whether the counselor should tell the family and the child that a report will be made. It is sometimes possible to retain one's anonymity in the reporting process, or to request that protective services not reveal the source of the report. However, the clinical issue involves the nature of the counselor's relationship with the family and the child, and the potential danger to the child if the family knows a report is to be made. If the family has a transient and chaotic lifestyle, there is a chance that they might pick up and move on if they knew a report had been made. If the parents feel that the child is bringing down the authorities on them, they may lash out at the child as a result of being forewarned of a report. Other phenomena operate in cases of sexual abuse. For both victim and perpetrator in incest cases, there is a higher risk of suicide after a report is made. Once the situation comes to light, the case must be handled swiftly and with expert timing (Tower, 1984). It may be useful to discuss with children's protective services whether or not a report should be revealed. The counselor may fear reprisals from a violent or unstable parent. Judgments to reveal or not reveal to families that one is making a report are difficult and must be based on a careful assessment of the situation.

In some instances, especially those where the family has established a working relationship with the counselor, it is important to consider the impact of the reporting on the therapeutic relationship. Many parents will suspect the counselor has made the report. If they ask the counselor and the counselor covers up, the dishonesty is counter-productive. Many counselors would argue that it is better, except in a situation involving great risk to the child or severe threats to the counselor, to inform the parents that one is legally obligated (if this is true) to report, that the counselor is concerned for the parents' well being and feels they are asking for help, and that the counselor will be there for them if an investigation takes place. The parents may be angry and dismayed (wouldn't we be?), but they will know that they can trust the counselor to be honest with them. Trust is a critical clinical issue with maltreating parents. They probably learned not to trust as children and need extra support to be able to trust a counselor. The counselor can also refrain from making any value judgments or drawing conclusions that the parents are abusive or bad people. The counselor might state, "I'm not saying that you abuse your child. I'm aware from what you have said that you feel Jimmy is very difficult and you go out of control a lot. I'm aware that you were severely punished as a child and that you feel several times you were physically hurt by the punishment. You and I have both seen bruises on Jimmy. I will tell protective services about the bruises, as that is my legal responsibility. But I am not making any judgments about you as parents. I am concerned for your needs, and I want to help." If the counselor weathers the initial angry reaction by the parents, a stronger helping relationship may develop, because the parents can learn that they won't be abandoned and that the counselor can be trusted.

Reporting suspected child maltreatment is not easy for the counselor. It involves difficult decisions and judgment calls. The counselor is advised to use supervision or consultation at this time. Elmer and Taylor-Brown (1985) advise setting up multidisciplinary teams in agencies to provide support for the reporting process.

Confidentiality and Liability

Counselors and other helping professionals are typically bound by requirements of confidentiality that information about clients will not be circulated. The ideal of confidentiality is superseded in practice by the legal requirement and moral responsibility of protecting children. Counselors should be careful not to make false promises of total secrecy to parents. They should also keep very careful records with the awareness that they might sometime have to go to court. In all states there is a presumption that a reporter shall be immune from liability for the act of reporting.

In point of fact, the counselor may be more prone to liability by a failure to report. Failure to report has resulted in civil liability suits, or criminal prosecution for helping professionals in several states, when a child was seriously injured or died as a result of nonintervention (Besharov, 1983).

There is a current dilemma for persons practicing in a substance abuse program that is federally funded. Under federal regulations, substance abuse programs connected with the federal government may not disclose any information from records, except as such disclosures are authorized. Disclosures for the purpose of complying with state laws on child abuse reporting are not specifically allowed. Breach of nondisclosure requirements is made a crime. "There is no easy resolution of the quandary faced by the substance abuse worker who discovers child abuse involving his or her clients who are substance abusers" (Saltzman, 1986, p. 475).

After the Report is Made

After the report is made, the investigation begins. The protective services social worker will contact the family, see the family and child, request medical evaluation if needed, interview collateral contacts, and make a determination whether the child is at serious risk in the home. Typically, in cases where the child is not at serious risk, the child will be left in the home, and supportive services will be used to stabilize the family.

The counselor's input may be useful in determining whether the child is at risk, or whether further evaluation of the family should be obtained. Kempe and

Kempe (1976) recommend the following guidelines for the need for a psychiatric assessment:

- When the family dynamics don't fit or match many or any of the standard basic histories found in 80 percent plus cases of abuse and neglect.
- When premeditated abuse has occurred--e.g., a father who planned the setting of the house on fire to burn his children.
- When torture has taken place, such as tying a child to a chair and burning him with a cigarette.
- When one part of the body is picked on--e.g., the left arm is repeatedly broken or the penis is repeatedly twisted.
- When there is distortion of reality and what the parent says just doesn't make sense--e.g., "My baby is a whore," "I caused my parents' divorce when I was 20 because I was conceived out of wedlock."
- Inappropriate responses to questions indicating a loss of affect--e.g., "How do you feel today?" "I don't have feelings."
- Severe depression.
- Religious or culturally based fanaticism.
- Drug/alcohol addiction.
- Bizarre ideas that seem to make little or no sense (p. 117).

A psychiatric evaluation may help determine a treatment prognosis for the parents. Psychotic parents can be a danger to the child if they are so disabled by their illness that they cannot function in a caretaking capacity. The paranoid schizophrenic client may be a danger if the child is involved in the parent's delusional system, e.g., "The F.B.I. is sending radio signals out through my baby." Character disorders or sociopathic personality disorders, typical of parents who have been in trouble with the law and have explosive violent histories, offer a poor prognosis and greater risk to the child. Parents addicted to drugs and alcohol cannot provide a safe environment or meet the developmental needs of the child when the addiction is not treated. This is an increasing concern because of parents using cocaine and crack. "Having ruled out a group of parents with a poor treatment prognosis, approximately 85 percent of abusive parents will remain whose personality diagnoses cover the spectrum seen in the general population" (Kempe & Kempe, 1976, p. 118).

The counselor should be very clear with the protective service worker if the problem of the parents seems to warrant further evaluation. The counselor should also let the protective service worker know if he or she will be able to continue counseling the child and/or parents. If the serious nature of the family problems is beyond the counselor's capacity or professional skill level, the protective service worker should be informed. Often protective service staff assume that if a family is in counseling, the situation offers a measure of protection to the child. Consequently, the counselor must be very clear about the limits of service. Counseling does not protect children from danger. Voluntary clients are free to leave. Involuntary clients may resist change. The counselor cannot guarantee the child's safety.

The assessment of whether or not a child should be removed from the parents is difficult. It is difficult to predict violence, and it is hard at times to determine to what extent a child may be at risk from neglect (Wasserman & Rosenfeld, 1986). If the counselor is offered an opportunity to provide input to the planning, the following factors should be considered:

Advantages of Separating the Child from the Parents:

- Immediate shelter and safety can be provided.
- Limits are set on parental behavior.
- The child may know he will be protected.
- Placement may temporarily free a parent of the burdens of parenthood.

Disadvantages of Separating the Child from the Parents:

- The child will blame himself for the separation.
- The child's attachment to the parent or his sense of identity may be disrupted.
- The child may believe his parent is right and he is wrong.
- Placement disrupts the equilibrium of the family.
- If the child has difficult behaviors he may be at risk for abuse in the foster home (Gil, 1979; McFadden, 1984) or residential treatment facility (Rindfleisch & Robb, 1982).
- With the current shortage of foster homes the child may receive an inappropriate placement.

- The child might experience multiple placements which would reinforce his low self-esteem and feelings of failure.
- The child might be separated also from siblings and other important people.
- The child might be placed in a different school district or community and lose continuity of service resources.
- The parents might become discouraged and not work to get the child back.
- It might take years to terminate parental rights and make the child available for a permanent home.

The decision to separate a child from his family is not one that is made lightly. To the counselor, it might seem like a painless solution to place the child in a "safe environment." Those who work in the child welfare system would be the first to point out its dangers to the counselors. Recent studies show a high rate of maltreatment in foster care (McFadden & Ryan, 1986). Other sources indicate negative effects of separation on the child (Bowlby, 1973; Littner, 1960).

CHAPTER 4
THE TEAM APPROACH

The complex issues in child maltreatment call for the use and development of interdisciplinary teams to meet the needs of the child and his family. A team is a group of professionals from diverse disciplines who pool their specialized knowledge for the benefit of the child and family. "The two major purposes of interdisciplinary teams in child abuse and neglect are (1) to understand the problem from a comprehensive perspective, and (2) to implement solutions which address all aspects of the problem" (Ziefert & Faller, 1981, p. 173). This chapter discusses some of the issues involved in developing teams, the counselor's role on the team, and the roles of the various team members.

The team approach originated in hospital-based management of child abuse and neglect. Originally, the doctors, nurses, medical social worker, physical therapist, and other hospital personnel met together to staff cases and work with child protective services and the legal system. Soon the team approach concept expanded to view the child protection worker as case manager and coordinator of all the range of professional services available to the child and family (National Center on Child Abuse and Neglect, 1975). Recently, paraprofessionals and lay persons have also been designated as team members. Foster parents are now included in case planning and staffing. Parent aides and homemakers provide valuable information to the team on the family's progress.

On some occasions, particularly when a momentous decision must be made, a wide variety of team members may assemble to staff the case. More often, one central person, usually the child protection worker, will coordinate information coming in from team members without getting all members together in one place.

Because the child and family may have tremendous needs, a wide range of helping personnel may be utilized in their behalf. One might find some of the following professionals as part of a team:

- child protection worker
- medical social worker
- doctor
- physical therapist

- psychologist or psychiatrist
- counselor
- *homemaker*
- parent aide
- child's teacher, or child care provider
- speech therapist
- foster parent
- advocate, attorney, guardian ad litem

In some situations, the biological parents are considered as a resource to the child and part of the team (Elmer & Taylor-Brown, 1985). Each of the disciplines has its own view of the child abuse problem, and each discipline has its own concepts and jargon. One of the issues involved in good team work is communication. Another is control.

In communicating across disciplines it is important to understand that other disciplines will view the same situation differently. In looking at the same family situation, the doctor may view the problem primarily as the management of the child's injury, the attorney may look at the family's legal rights, the educators will be concerned about the child's cognitive development, the counselor may be concerned about the child's feelings and self-esteem, the foster parents may be concerned about the child's bedwetting, the parent aide may think the central issue is the parents' isolation, the psychologist may be concerned about the parents' psychopathology, the physical therapist may be concerned that the foster parents should get the child to appointments on time; and the homemaker may be concerned about the parents' poor housekeeping. Rather like the fable of the blind men feeling an elephant, the team members' perspectives will be limited by their professional orientation and the task they perform for the child. This type of situation can occasionally leave the counselor feeling "no one really cares about the child and how he is feeling." It is important to keep in mind that each perspective has intrinsic value, and that when all views of the situation are combined, they create a larger picture. It is extremely useful for the counselor to get the perceptions and reports of the other disciplines.

A related concern is one of language. The counselor should not be embarrassed at team meetings to ask the other professionals what their jargon means. When the doctor mentions "subdeural haematoma" or the attorney says, "the difference between adjudicatory and dispositional processes," the counselor should ask, "Could you explain the meaning of your technical terminology?"

Control can be a serious issue in team formation. Medical personnel are typically accustomed to a hierarchal form of decision-making in which health professionals provide input to the doctor who makes the final decision. Although the "medical model" is changing, the counselor will note a tendency on the part of some team members to defer to the doctor. The responsibility of protecting the child rests with the child protection worker who feels the primary pressure of managing the case. Those who feel most powerless, often the foster parents, may feel the most anxious about who is controlling the outcome for the child. Everyone on the team may at times feel powerless when an unanticipated court decision occurs which contradicts an opinion or recommendation of a team member. The counselor's training and skills in interpersonal relationships will be invaluable in helping the team work with the issues of control and anxiety. Because choices in a child abuse situation can be quite anxiety provoking, the team needs to provide support in mutual decision-making. Decisions to remove a child or return a child may be addressing potentially life and death issues. It is a comfort and an aid to good decisions for the team to be involved together in planning major changes.

The question of confidentiality again arises vis-a-vis team planning. Some communities which have child abuse coordinating councils, S.C.A.N. (Suspected Child Abuse and Neglect) teams and similar team approaches have worked out forms or agreements between agencies so that there can be interagency communication and cooperation. However, this does not abrogate the counselor's need to obtain client permission to discuss their situation with others. If working with the parents, the counselor needs their consent to share information. If working with the child only, the counselor needs to check with the child's worker to determine the legal status of the child, and whether parental permission is needed, or if the consent of the court or worker is sufficient.

The counselor may need to clarify his or her role with other team members. Misperceptions may range from a foster parent not seeing the value of counseling, e.g., "All Susie does there is play and she still doesn't mind better," to a child protection worker's feeling that the counselor must have some valuable secret information that isn't being shared.

The most important role clarification a counselor may have to do is to reiterate his or her belief that counseling alone cannot protect the child (Cohn, 1979). In fact, it could conceivably be dangerous to the child to help him express anger about the abuse or to uncover a parent's feelings of deprivation if there are not other supports built in to protect the child. It is also important to remind members of the team that complex family problems cannot always be solved through counseling or on a timetable meant to satisfy the court case review schedule.

If the parents are ordered by the court or the caseworker to continue counseling, the involuntary nature of the relationship may become an obstacle. With time and the client's testing of the counselor's trustworthiness, the counseling situation can be changed so that the client--parent or child--feels it is for him, not forced on him. Other members of the team may need help in understanding why counseling can be such a time-consuming and painstaking process.

Members of the Team and Their Roles

1. Medical

The child's physician will have evaluated the child's health and growth and made a determination as to the presence or absence of maltreatment. It is important that the child's health and development be monitored by a physician who knows the child and that information from specialists be coordinated. The child's parents may resist a continuing relationship with the physician who "betrayed" them. While it is important to the counselor to allow parents or child to ventilate about the physician, it is equally important to support the idea of continuing medical care.

The child's physical therapist may be helping the child regain use of an injured body part. If the child is in pain or discomfort and the physical therapist is attempting to increase the range of motion, the child may complain about seeing the physical therapist. The child may resist visits to the laboratory for blood work. The foster parent or parent may complain about the time spent in transporting the child. As a team member, the counselor has an ideal opportunity to help the child master fears of body pain and, with the parent figures, uphold the goals of medical treatment and reinforce the importance of the parents in providing it.

II. The Child Welfare Agency

The child protection worker (or foster care worker) is involved with case planning for the child and family, provision and coordination of resources to help the family, monitoring the child's progress in the home or foster home, and reporting periodically to the court. Typically, child protection workers struggle with large caseloads and crushing responsibility. They must handle the frustrations of working with a court that does not always implement their recommendation. Child protection workers often are negatively perceived by parents and have to handle a lot of anger from clients. They some times envy the role of the counselor, whom they may perceive as having an easier job and more positive relationships with clients.

The child's foster parents may perceive themselves as trained members of a professional team, or just as plain folks who are in a parenting role with the child. Ideally, if foster parents have been carefully recruited, screened, and trained, they will have considerable knowledge of the child to share with the team. With proper training and support they can work with the biological parents to ensure a successful transition of the child back home. Foster parents can work well with counselors if they understand the counselor's role and the purpose of counseling. Training materials such as Fostering the Battered and Abused Child (McFadden, 1978) and Fostering the Child Who Has Been Sexually Abused (McFadden, 1986a) are available for foster parents to increase their skills in meeting the child's special needs. Foster parents have several pet peeves about counseling:

- Foster parents do not understand how the counseling is helping the child. "All she does there is play." "All he does is complain, why doesn't the counselor teach him a more positive attitude."
- Foster parents want quick behavioral changes, because they find the child difficult to manage. They may feel that the counselor sees the child only one hour a week, and that they have to put up with his problematic behaviors 24 hours a day, seven days a week.
- Foster parents may feel they are being treated like clients (parents) rather than as team members by the counselor. They don't want to feel blamed for the child's problem when it was the parents who caused the child's problem in the first place.
- Foster parents need all the information they can get to help the child and resent caseworkers or counselors who do not give them full information.

This can create problems when the counselor feels obligated to maintain confidentiality with the child.

Counselors are in an ideal role to advocate for increased foster parent training. Relationships with foster parents can also be facilitated by treating them as members of the team; providing adequate information; involving them in plans for the child; informing them when the child is likely to have a hard time; planning with them to help handle difficult behaviors; explaining the purpose and techniques of the counseling strategies; and providing them with readings and resources for the child.

III. Educators and School Personnel

The school social worker may act as a liaison between the school and the child's parents and coordinate special educational resources for the child. The school psychologist may test the child and make recommendations for special educational programming to meet the needs of the child. The school nurse may be in an ideal position to monitor the child's day-to-day health and be alert for the possibility of new bruises or injuries.

The child's teacher can do a great deal to help the child recover from the effects of the maltreatment. A planning session between the counselor and the teacher may be useful in developing a healing classroom atmosphere for the child. Maltreated children need to improve their self-image and to be able to "do something right." Carefully planned classroom activities, such as feeding the gerbils, may increase the child's self-worth. The use of affective education techniques in the classroom can complement the counselor's work with the child. The teacher of a disruptive child can plan, with the counselor's help, disciplinary techniques which focus on the child's strengths and help build more positives into interaction (Tower, 1984). The counselor and teacher can also plan ways of working with the parents or foster parents, or both, to enhance the child's cognitive and social development. If the child is moved to a new school district, the counselor and teacher can confer with their counterparts to provide continuity of planning.

IV. Legal

The parents' attorney may be a valuable ally in helping the parents to utilize counseling. He or she may be able to convince the parents that counseling will increase their chances to keep the child in their custody or to have the child returned to them.

The child may have a separate attorney, guardian ad litem or advocate appointed to represent the child's interest in court proceedings, and to monitor effectiveness of the case planning for the family and child. The child's advocate may be interested in knowing from the counselor if the child's needs are being met by the plan, if the agency is discharging its responsibilities properly, and if the child is faring satisfactorily with the family or in out-of-home placement. The advocate may ask about the child's desire to be with the parents, the effects of separation trauma on the child, or the strength of parent-child attachment. The counselor must be careful and thorough in responding to such inquiries, as information on the child's emotional situation can have a major impact on knowledgeable judges.

Resources for the Parents

Parent aides, homemakers, parent education groups, parent activity groups, consumer counselors, volunteers, family life educators and others play a valuable part in supporting families, reducing stress, decreasing isolation, and teaching new skills. Such team members often have the most supportive and close working relationship with the family, as other members of the team are perceived to be agents of social control, or more interested in the needs of the child. If the counselor is working with the parents, it is very helpful indeed to coordinate with the other people involved in the services to the family. If the counselor is helping a depressed mother with self-esteem issues, the parent aide can take her shopping or to a free make-up demonstration. If the counselor has concerns about the care given to a child still in the home, a report from the homemaker who is present daily can provide accurate information.

A Comprehensive Approach to Helping Families

In an evaluation of 11 child abuse treatment projects, Cohn (1979) found that treatment alone does not guarantee a child's safety, that 30 percent of the children experienced reincidence of maltreatment, and that the single best predictor of reincidence appeared to be the severity of the case at intake. Perhaps the most significant finding of this study was that lay services (parent aide counseling and/or the Parents Anonymous self-help group) were more cost effective and reduced the propensity for reincidence more than individual services of a counselor.

Many experts agree that treatment programs and resources for parents are far more numerous than treatment programs for children. There has been a notion that the best way to help children is by helping their parents (Cohn, 1979), and this may be so. Garbarino (1983) states, "Nearly all current treatment addresses parents. Exclusive treatment of parents does not appear to reverse damage to children. Children generally receive no treatment at all and may even be harmed by outside intervention that places them in foster care or institutional care that is often traumatic in its own right" (p. 5).

Just as parents need supports in their lives, maltreated children need additional supports to help in their development. The counselor is in a unique position to recommend additional services for the child as part of a treatment package. Typically a young maltreated child may need a developmentally enriched nursery school setting. An older child may need speech therapy, a physical activity such as swimming to build motor coordination, a group such as scouts to build social skills and moral development, or an activity group to increase self-esteem.

Martin (1976) recommends a specific child protection team format to be used at the time of referral, and at every point thereafter when treatment planning is being considered or reviewed. The topics to be covered include the following:

- What is the developmental status of the child?
- What are the child's reactions to recent events in his life (injuries; medical evaluation and treatment; separation from parents, siblings, surroundings)?
- What other factors in the child's home, besides abuse, are deleteriously affecting his growth and development?
- What are the treatment needs of the child (pediatric care; speech therapy; physical or occupational therapy; educational therapy; psychiatric therapy; continuations of previous meaningful relationships with relatives, neighbors, peers, teachers)?
- What effects will the treatment recommendations for the whole family have on the child? (Consider the effects of long-term foster care, court hearings, visiting privileges of parents, evaluation and treatment of the parents, home visits by professionals.)

- Who will be assigned to monitor the child's subsequent course and progress?
- Has the parent-child interaction changed? (pp. 283-284)

It is useful to identify strengths of the family and child on which to build further and increase competence. The counselor's role is strengthened and clarified by a candid acknowledgment of the limitations of counseling and an insistence on mobilizing a variety of supports for the family. When the family is being supported through a variety of helping interventions, the child will be safer and have greater opportunity to unfreeze the arrested developmental processes. Through effective use of a team approach, the counselor can be a harmonious part of a coordinated effort.

CHAPTER 5
COUNSELING THE INDIVIDUAL CHILD

Developmental Issues: An Introduction

Counseling the individual child can be one of the most gratifying areas of work in child abuse and neglect services. In comprehensive treatment of children, many of the children's problems are partially or totally resolved and at higher rates than are seen for families (Cohn, 1979). Watching the development of trust, or seeing a selectively mute child begin to express verbally a torrent of pent-up feelings, is rewarding indeed.

One of the primary purposes of counseling the maltreated child is to provide a safe place and safe relationship within which the child may experiment with new adaptations to a safer world. The climate of safety helps to get the child's arrested development "unstuck." Researchers consistently agree that there are critical periods for certain types of development and that the effect of maltreatment is to arrest or freeze developmental processes (Helfer, 1975; Martin, 1976). Disrupted or minimal bonding is related to many of the developmental difficulties. "Children mature through a process of bonding or attachment with parents or other specific adults. Bonding is a two-way, two-person process. The child requires at least one specific adult willing and capable of becoming so attached. The bonding concept refers to the emotional quality of the child/adult relationship as differentiated from custodial care or dependency relationship" (Brody, 1978, p. 592).

Counselors cannot literally or metaphorically replace the requisite parental bonding, but do have an opportunity to help the child develop a more appropriate and trusting relationship with an adult. In a literature review of research on "superkids," those seemingly invulnerable children who prevail despite horrendous backgrounds of parental substance abuse, mental illness, neglect and abuse, Pines (1980) noted several important characteristics of the "superkids." They were constitutionally strong and attractive, well-endowed genetically. They possessed the ability to withdraw from parental pathology and entertain themselves in a safe way until the crisis moment passed. Most significantly, they all managed to reach out to an adult figure outside the family to receive nurturing support and encouragement. The counselor is in an ideal role to help innoculate children with hope, positive regard, recognition of their competence and other elements which will protect their self-esteem from the chaos at home.

In working with maltreated children, counselors need to be aware of the normal developmental milestones and tasks for children of various ages and must also understand some of the ways in which development can be arrested. Figure I indicates some of the typical developmental issues a counselor might observe in work with maltreated children.

It is important to understand that arrested development is often the result of years of deficits and that one may not see improvement overnight. The key to understanding the maltreated child is to look at the developmental stage, not the chronological age. The counselor will see an eight-year-old in a fifteen-year-old body. The counselor may see a nine-year-old who never really learned toileting. The counselor may see a seven-year-old who decided at age two that it was too dangerous to talk and has been selectively mute ever since. The counselor may see a twelve-year-old who has never learned to play.

The key to success in working with maltreated chldren is determining the stage at which development became stuck and using approaches relevant to the earlier stage. A seven-year-old who never received adequate nurturing spied a doll and baby bottle in the counselor's office. Instead of giving the bottle to the doll, the child lay on the floor with the bottle and, watching the counselor carefully, said, "I'm a baby now." In the period of temporary regression, the child was open to some positive nurturing from the counselor and experienced, to some degree, the trust she had lacked in infancy.

A second key to working with abused children is understanding that children grow from stage to stage and that the stages are orderly and sequential and cannot be skipped. Therefore, if Jamie's presenting problem is "stealing" and not sharing, we need to look at the stages that have been skipped. Before he can learn to respect other children's property rights in the here and now, he has to redo several important steps of development that he missed. Jamie needs to acquire empathy, a sense of caring and putting himself in the other child's shoes. He also needs to learn the concept of property rights. In a chaotic and disorganized home, with few boundaries, little adult supervision, and a lack of material resources, Jamie never had anything that was his very own. There were very few toys and they weren't shared--the strongest, toughest child got the toy he wanted, at least temporarily. Jamie did not have a room, a bed to sleep in, or any clothes that were just for him. In order to help Jamie, the counselor had to work with his teacher and foster parents to provide Jamie with his own possessions. At the same time that the adults in Jamie's environment were simultaneously setting firm limits and satisfying his needs, the counselor was working with Jamie on the development of empathy. In order to learn to feel for another, a child first has to learn to have a positive feeling for himself. Through play, discussion, records, picture books and classroom activities, Jamie began to believe that he was someone valuable and that people could care about him. Once that step was accomplished, Jamie was more able to understand the importance of "the rules" and that other people have feelings too.

In thinking about the development of maltreated children, we need to be aware of all the developmental spheres and the effect that maltreatment may have produced in each area. In assessing a child we need to look at the following developmental dimensions:

Physical development--the child's health, size, weight, strength, energy level, fine and gross motor coordination, neurological immaturity related to low birth weight or premature birth.

Emotional development--the child's ability to trust, form relationships, identify and express feelings, tolerate frustration, control impulses, distinguish fact from fantasy, have a sense of himself as a separate person, and develop self-esteem and identity.

Cognitive development--the child's ability to use symbols, develop language, understand cause and effect, move from the concrete to the abstract, remember images and concepts, perceive relationships in space, organize information.

Social development--the child's ability to engage and interact with others, play by the rules, give and receive social "strokes," handle new people and experiences.

Sexual development--the child's feeling about the body, the exploration of the body, expression and control of sexual impulses, development of secondary sexual characteristics, understanding and handling issues of sexuality.

Moral development--the ability to empathize with other people, to understand the necessity and fairness of "the rules," to internalize the rules, to think about consequences of behavior to self and others, to develop personal values and ideals.

These dimensions of development are interrelated, and trauma or deficits in one area can often affect development in another area. For example, the failure-to-thrive infant, who lacks emotional closeness and bonding, will manifest symptomatology in the physical dimension by not growing. The child who has experienced deficits in the emotional dimension through lack of nurturing will have difficulty in the moral dimension due to lack of empathy and an inability to delay gratification. In the case of sexual abuse, the child whose development in the sexual dimension is severely traumatized will have emotional consequences such as fear and lack of self-esteem. The child who has been prematurely eroticized will have difficulty in the social dimension due to inappropriate or promiscuous behavior.

Developmental Assessment

The counselor needs to obtain a great deal of developmental information about the child in order to be able to assess how and at what period of growth the trauma occurred which caused developmental lag. Talking with members of the child protection team may provide much needed information. School records and public health nurses may have additional information on developmental milestones attained or delayed. The best source of information is probably the child's parents, even though they may withhold or distort some of the information. As the information is gathered, the counselor will develop one of several hypotheses. The child may never have gotten quite enough of what was needed all the way down the line, so the task would be essentially a resocialization project with the child. The other possibility is that there were specific major traumatic events which intruded on the child's life and development and that developmental deficits are clearly reactions to those events, e.g., the child who was burned, hospitalized, and exhibited consequent serious emotional regression. In the latter case, the counselor may be more involved in helping the child work through earlier traumas, once the child feels truly safe.

Figure I

Some Developmental Issues of Children

Stage	Normal Developmental Process	Development Interrupted by Sexual Abuse	Development Interrupted by Physical Abuse
I: Infancy	Little control of body, rapid change. Learns to trust. No sense of right and wrong. Must be touched and held to thrive. Discovers own body parts, explores genitals, fingers, toes. Touching genitals, or rubbing against crib or toy feels good.	Infants who have been sexually abused may have physical effects. We see eating problems and sleep disturbances. These children need lots of nurturing. Children sexually abused later often did not get basic needs met in infancy.	Excessive crying, irritability. Unresponsive. Difficult to comfort. Failure to thrive, developmental delay. Disrupted bonding to caregiver.
II: Preschoolers	Gains some control, coordination of body, moves about independently. Begins to communicate through speech. Relates to more adults and other children. Often overwhelmed by intense feelings. Struggles with feelings of doubt and shame. Curious about body parts and differences between boys and girls. Plays 'house' or 'doctor'. Touches own or playmate's genitals. Also fascinated with elimination. Uses bathroom words like "You're a big B.M." or "She is a poo poo."	Desperate need for love. Difficulties in communication, and in trusting adults. May not feel guilt about sexual abuse, but feels worthless. Does not understand what sexual abuse is about--uses denial to repress feelings. Child uses a lot of sexualized play to communicate feelings. Wetting, soiling may indicate a cut off from body sensations.	Poor coordination, passivity or lethargy. Extremes of hyperactivity. Panics in response to pain, or does not react at all to painful experiences. Impulsive destructive behavior. Difficulties in playing and relating to others.

Adapted from Fostering the Child Who Has Been Sexually Abused by Emily Jean McFadden, Eastern Michigan University, 1986.

Stage	Normal Developmental Process	Development Interrupted by Sexual Abuse	Development Interrupted by Physical Abuse
III: Usually School-Age	Develops good physical coordination. Thinks about cause and effects. Concerned with fairness and rules. Conforms to expectation of others. Develops self-esteem through accomplishments and positive relationships with adults. Enjoys sexual experimentation, like games of "who can pee the farthest," letting family dog lick genitals, or mutual touching of genitals between friends. To the child this is "play" and is not frightening. Curiosity about bodies may lead to "peeping" or looking at pictures. Experiments with "dirty words."	Has negative feelings about his or her own body. Compliant, afraid. The world is unpredictable. Learns he or she is "different." Has difficulties with other children. Feels ashamed. Feels unworthy. The only way to get attention is by allowing adults to use their bodies. Sexually overstimulated. May disconnect from body sensation, feel revulsion, or have conflict with mixed feelings. Sexual experience may be powerful and frightening, or it may lead to behavior which seeks further gratification.	Withdrawal, apathy, depression. Speech difficulties. Anti-social behavior, and aggression. Regressive behavior, typical of earlier stages. Compulsive activities and mannerisms. Tries too hard to please adults. Unwilling or unable to do things for self. Deterioration of relationshps with peers, adults. Fears of illness, body injury. Problems with fine motor coordination.
IV: Usually Adolescence	Physical maturity makes youth able to conceive or impregnate. Menstruation and nocturnal emissions are reminders. More awareness of sexual drives. Increased concern and worry about body and appearance. May feel as if body is out of control due to all the changes.	Anxiety may cause damage to body or health through self-mutilation, sleep disorders, eating disorders. Youth may be disconnecting from body sensations for self-protection.	Adolescent may regress (move backward) or remain fixated (stuck) at earlier level of development. Has difficulty planning for future or moving ahead in goal directed way.

Stage	Normal Developmental Process	Development Interrupted by Sexual Abuse	Development Interrupted by Physical Abuse
Adolescence (cont.)	Oriented to friends of same age. Have many activities in common. Conflict with parents is a way to express independence, and prepare to grow up. Sometimes worry, feel inadequate, but generally feel OK, with a variety of mood swings. Plans for the future. Teens begin experimenting with sexual intimacy with opposite (or sometimes same) sex partner of same age. Begins developing attitudes and values about their own behavior.	Feels different, unpopular. May use sexuality or seduction to try to gain friends. Still compliant with perpetrator. May finally take great risk with disclosure. Chronic feeling of worthlessness, failure. Often thinks of suicide. Has trouble thinking about the future. Behavior is often promiscuous. Vulnerable to exploitation, disease, premature parenthood, and victimization.	May be extremely rebellious, or dependent like a much younger child. May continue to have difficulty with physical aggression, fights. Feelings of worthlessness, low self-esteem.

Stage	Development Interrupted by Neglect	Development Interrupted by Emotional Abuse or Neglect
I: Infancy	Infant has no expectation that there will be a response to his cries. Problems with basic trust. Infant often passive, does not interact socially. Weak bonding to caregiver.	Basic trust not formed. Infant may display rocking, head banging, other self-stimulating behaviors. Little or no bonding.
II: Preschoolers	Child's behavior becomes chaotic, due to lack of supervision, limits. Little control of body, usually lacks toileting skills. Little language develops. Failure to organize world in meaningful way. Play is extremely primitive. Aggression may appear.	Child may withhold language. Child not bonded to caregiver. Approaches adults randomly for attention. May appear "outgoing" or "affectionate," but is actually desperate for attention. Difficulties in interacting, sharing with other children.
III: Usually School-Age	Adjustment difficulties in school Responds to social ostracism by withdrawal, sleeping in class, or lashing out. Learning difficulties in school. Can't follow through on assignments. Working under grade level. May be placed in Special Education classes.	Diffulties understanding cause/effect, or distinguishing fantasy from reality. School progress uneven. Vulnerable to sexual exploitation, other forms of victimization.

Stage	Development Interrupted by Neglect	Development Interrupted by Emotional Abuse or Neglect
School-Age (cont.)	Speech is primitive. Physical health is poor. Often hungry, sick. Needs external structure. Very little "conscience" or understanding of rules. May show extremes of apathy or aggression.	Fearful of loss of parents. Anxious about adult/child relationships. Immobilized by frequent worries. Develops inappropriate ways of seeking attention, receives negative feedback. Bizarre mannerisms. Poor relationships with peers. Difficulties sharing, taking turns. Regressive, babyish behavior. Difficulties following rules, will break them to test limits.
IV: Usually Adolescence	Has not internalized controls. Moral development delayed. At risk for delinquent behavior. Easily influenced, eager for material things. Likely to drop out of school, get caught in poverty cycle. Cognitive development fixated at much earlier stage. Little hope for a positive future. May have developed a "tough bravado" to conceal lack of self-worth. Experiences less conflict with parents as they are disengaged. Drifts off, rather than leaving home planfully or rebelliously. Still prone to illness, poor health.	Remains fixated at much younger level. Does not develop a sense of self, nor move toward greater independence. With little sense of self, can't tolerate intimate relationships. Relationships often hostile--dependent with excess of manipulative behavior. May be extremely withdrawn, have little contact socially. Preoccupation with fantasy world. Will run away when threatened by too much closeness. High risk for suicide, substance abuse, self-inflicted or "accelerated" injury.

Developmental Adaptation: Repetition of Patterns

Children who have been traumatized may seek to deal with their complex emotions by reenacting the original frightening event. We see this type of reenactment frequently in children's play. Sandy spanks the doll, Ricky punches the teddy bear, and Leroy "humps" the cocker spaniel. Play is a relatively safe way of reenacting scary memories. A more dangerous way to reenact the traumatic event is by replaying it with other people. Littner's classic article, "The Child's Need to Repeat His Past," details the dynamics of the phenomenon and gives an example of a little girl who reenacted the dynamics of her biological family through foster and adoptive placements (Littner, 1960). Sexually abused children may attempt to master their fears by becoming the aggressor with another child or allowing themselves to be revictimized (Brandt & Tisza, 1979). The child who was sexually abused in her own home may set up similar dynamics in the foster home by orienting to the foster father, avoiding the foster mother, and behaving in a "seductive" manner (McFadden, 1986a; Stovall, 1984). According to Gruber (1981), children often actively seek out or willingly receive affectionate behavior from adults, and in their attempts to attract adult attention, they naively engage in what appears to be seductive behavior.

Additionally, abused children become involved in complex interactional patterns with their perpetrators as a way of getting their needs met. If Jonnie needs attention and Mom is indifferent, he may have to resort to a dramatic behavior to elicit a response from Mom. When she hits him, she feels guilty and bad. So mother says, "Come on Jonnie, I'll give you an ice cream cone." What has Jonnie learned? He has learned that if you get hit, there is a reward at the end of the line.

If Jennifer has been raised in a truly neglectful situation in which she gets none of her emotional needs met, she may experiment and learn that if she kicks Mother, Mother will yell at her and maybe even slap her. Children need verbal stimulation and touch. If yelling and slapping are the only verbal contact and touch Jennifer obtains, to her it is better than nothing at all. Straus and Gelles (1980) indicate that the child who has learned to provoke a caregiver by hitting or other physical contact is at far greater risk to perpetuate the continuation of violence.

As the child has internalized these maladaptive ways of getting basic needs met, it is not surprising that teachers, nurses, foster parents, and other caregivers find themselves inexplicably having an impulse to behave abusively toward the child. Without help, the child will carry maladaptive interactional patterns into other relationships with adults. In working with maltreated children, we are aware of at least four types of interactional patterns which children may repeat in the counselor's office:

> **The hider** has learned to survive by withdrawing at the first sign of tension. He is hypervigilant, scanning the environment for the first sign of adult disapproval. When he becomes anxious, you may find him behind the door, under the table or crouched small in a corner. The counselor may spend the better part of a session on the floor (at a safe distance) trying to persuade the hider it is safe to come out.
>
> **The provoker** may want to find out how safe she is with the counselor and may figure that she will put the counselor to the test right away. Or, she may have a maladaptive way of engaging the counselor's attention. The counselor may be startled when punched, slapped or bitten by the provoker.
>
> **The caretaker** who is the pseudomature victim of role reversal may try to ensure her safety with the counselor by solicitously inquiring about the counselor's mood, health, hunger and sleep patterns. She may offer the counselor a candy bar, a penny, a backrub or herself.
>
> **The scapegoat** who has learned he is to blame for all problems will spill the crayons, stumble over furniture, knock over the blocks or trip himself on the counselor. He will then present himself to the counselor to be punished, with clear conviction that he deserves the worst. The counselor may find himself momentarily reacting as if this is a bad kid who does need punishment.

In assessing the needs of the maltreated child, it is important to identify maladaptive patterns which the child has developed. If the counselor cannot immediately discern such patterns, it is a good idea to check with teachers, foster parents and other caregivers. They often become aware of the patterns by analyzing their own visceral responses to the child, e.g., "I don't know why, but there is something about that kid that makes me want to shake him, and I usually love kids."

It is a top priority for the counselor to work with the child to eliminate patterns of behavior which might put the child at risk for further abuse or exploitation. This is accomplished by identifying patterns; not allowing oneself to respond in the manner which the child anticipates; discussing with the child why you are behaving as you do; talking and showing the child other ways of behavior; and reinforcing appropriate behavior. This may involve close work with the teacher, parent or foster parent, encouraging them to "catch the child doing something right" and reward more appropriate behavior. Even a young child can understand the following counselor instructions:

- "Sarah, I can't allow you to hit me. Hitting hurts, and I don't hurt you, and I can't let you hurt me."
- "Nicky, I know sometimes going to a new place is scary. You don't know me yet, and you probably feel safer under the table. But I won't hurt you, I promise. I'll sit here until you feel more comfortable and feel like coming out and playing."
- "Ramona, I know you're trying to be nice by touching me that way and offering to rub my back. But people don't touch other people on their private parts, and children aren't supposed to touch adults or take care of them that way. Let me show you how I like to touch. Shaking hands like this is the way we touch people when we first meet them."
- "Lenny, you haven't done anything wrong. You just tripped over the rug. It was an accident. I won't punish you for something that is an accident. You are behaving yourself well. I like the way you were trying to put your toy away."

The counselor's office is the safe environment maltreated children need to experiment with new behaviors and to learn different ways of interacting with adults.

The Importance of Play to Maltreated Children

Play is the work of children. It is the way in which they express feelings, gain large and small motor coordination, learn cause and effect, develop object constancy, and master their environment. It helps them to try new roles and practice growing up. According to McKee (1986), "Today, more and more stressed children have less and less time, space and materials for play, and fewer helpful adults who encourage their playful pursuits and are available or willing to engage in play partnerships with them. Concerned adults report an increasing number of children who do not and cannot play constructively due tc malnutrition, neglect, overwhelming anxieties, unrealistic adult expectations, perfectionism, severe handicaps or crises such as family separation, divorce or abuse. Yet researchers, clinicians, educators and humane parents concur that all children need play as a working partner in the childhood to ensure their healthy, harmonious and happy development" (p. 5).

Most maltreated children have experienced severe deficits in play. Fear of parental wrath may have inhibited spontaneous movement. Neglect may have caused a child to remain isolated in a crib or playpen in the formative years. Exposure to sexual activity or sexual abuse may have eroticized the child's play and stolen the innocence of childhood. Being cautioned day in day out to sit still in front of the TV may have developed a very passive mode of interacting with the world.

Some children need to learn to play. They will need much support and encouragement to pick up toys or make sounds. They may appear bewildered and confused about the purpose of a toy. They may need as much "play partnership" assistance from the counselor as a much younger child would.

One typically thinks of using play therapy with young, preschool-age children and switching to games or activity therapy with school-age children. However, with maltreated children, developmental stage, not age, is the key to determine which type of play the child will find most helpful.

Seven-year-olds, ten-year-olds, even an occasional adolescent, may utilize the dollhouse or the clay in a way that a much younger child would. If a nine-year-old plays with clay and begins fashioning "poopies" as a preschool-age child might, the counselor can feel confident that the child is going back to rework an earlier painful situation, and that this activity is helping the child to move ahead developmentally, even though at the moment it appears regressive. The counselor should allow older children and youth equal opportunity to play. For older children, as for younger children, play can help to rebuild a damaged body image; tell the story of an earlier trauma; help the child handle separation; help the child to develop trust in the counselor; and teach new social skills.

Burch (1980), in a clinical case study of a thirteen-year-old boy who had been physically and emotionally maltreated, describes the use of puppet play to remember, repeat and work through the earlier trauma:

> He became intrigued by two hand puppets: a green rather aggressive looking parrot and a red bird, which resembled a woodpecker. In this hour he began to talk over some pubertal concerns stimulated by scenes from the Roots television broadcast in which women's bodies were exposed and sexually abused. When the anxiety became unbearable for direct communication to proceed, Carl interposed the medium of the puppet to ask his questions. (p. 81)

Play enables children to create a safe distance from which to address frightening or painful topics; e.g., it is not Tommy being beaten, it is the bear; it is not Aaron who is so angry with the mommy doll, it is the little boy doll who is so angry. In observing the child's play, the counselor should refrain from making interpretations for the child. The child is not able to handle acknowledging the rage that is directed at Daddy, so the counselor does not interpret the play, but just reflects back "the little horse kicked the big horse."

Counselors find that of all therapeutic modes, play and other creative expression such as art therapy are most useful in helping the child to unblock arrested development. Art work of the child who has been maltreated or witnessed maltreatment will be a rich source of information for the counselor. The child's drawing of himself, the house, and the family will express a multitude of concerns. Drawings may vividly depict a child's sense of isolation or powerlessness. The aggressive child may draw big dangerous arms with long fingers, while the child who feels inadequate forgets to draw any hands at all. Overattention to genital areas indicates sexual abuse or anxiety about sexuality (Wohl & Kaufman, 1985).

In order to feel free to draw, the child or youth needs many reassurances that he or she is not expected to "be an artist" or to stay within lines. There is no right way or no wrong way to do it. The counselor does not interpret the drawings back to the child, but rather asks the child, "Can you tell me about the family in this drawing?" Again, the counselor is cautioned not to interpret to the child that this is her family--it is only the family in the drawing.

Special Issues in Counseling Maltreated Children

In addition to the developmental lag, repeated patterns, and paucity of play experience discussed above, there are several other critical issues which impact on the counseling situation. The first issue is that it is far more difficult to establish trust with a maltreated child than with other children. One of the most profound developmental deficits is the failure of an adult caregiver to give the child a sense of order and predictability (Helfer & Kempe, 1976; Martin, 1976; Mayhall & Norgard, 1983). The child never knows what to expect next and is anxious about interactions with adult figures. In order to alleviate the child's mistrust, it is important to explain the counseling situation; explain why there is a closed door; offer to leave the door open if it would make the child more comfortable; remind the child that you won't hurt him; ask the child if there is anything frightening about the office; ask the child if you have done anything that might frighten him; etc. It is important to check with the child for feedback on the degree of comfort and trust he may be experiencing.

The counselor should be very clear with the child about the limits of confidentiality and must not promise the child to "keep a secret" if it is something that must be revealed to the child protection team, the teacher or the foster parent. The child will not easily forgive the betrayal of a confidence. It is especially important with children who have been sexually abused to avoid promises that a particular confidence will be "our secret." To sexually abused children, secrets mean sexual abuse.

It is important not to move close to the child too quickly, but rather to allow the child to approach you at his or her own pace. Particularly with younger children, stay on the same latitutde with them (Salter, Richardson, & Kairys, 1985). Bend down, sit in a small chair, and try not to tower over them. With sexually abused children who may have been anally penetrated, be careful not to approach them from behind. With physically abused children, make no sudden moves near them. The child will let the counselor know by his nonverbal approach behavior when he is beginning to trust.

Limit setting is critical in counseling sessions with maltreated children. Both abused and neglected children have a problem with being aggressive (Bender, 1976; Timberlake, 1979). Regardless of age, maltreated children or youth may not have internalized normal controls. In witnessing or being the recipient of violence, they may have learned to behave violently to ward off anxiety, to receive attention, or to discharge tension. The counselor needs to have clear limits established that, "I won't hurt you, and I won't let you hurt me or anyone else around." The child may be terribly frightened of his own rage and be dealing with it by a combination of denial and suppression. The counselor is cautioned against making any direct interpretations of the child's anger and aggression, and is warned that an aggressive outburst by the child may erupt if the counselor is helping the child to express feelings or trying to uncover painful memories. The counselor's limits, and the counselor's ability to maintain limits, will increase the child's feelings of safety in the session.

The counselor should always be attuned to the potential of self-destructive behavior or suicide with maltreated children. The combination of early trauma and actual or threatened loss of a caregiver puts maltreated children in a high risk category. Many maltreated children suffer from a pervasive and chronic depression which can be viewed alternately as anger turned inward, or a cry for love and nurture that was never forthcoming. Suicide attempts have been documented even in young children (Husain & Vandiver, 1984). The counselor should be alert for indicators such as serious self-mutilation, anorexia, risk-taking and accident prone behavior, statements of despair or futility, and the child or youth giving away prized possessions. If the counselor suspects the possibility of suicide, he should ask, "Have you ever thought of doing yourself in?" If the risk is high, that is, if the child has a plan and a means to kill himself, the counselor should arrange for immediate help.

One of the critical issues in working with maltreated children is that of trying to increase their self-esteem. Although many authorities agree that low self-esteem is a problem among maltreated children, it is not necessarily the direct consequence of the maltreatement, but may instead be related to other factors such as poverty or poor relationships (Weinbach & Curtiss, 1986). Kinard (1982) noted a lack of consistent evidence that abuse victims suffer from this problem. The counseling issue is not the obvious one of building self-esteem if it happens to be low, but rather the more ticklish proposition of risking reducing the child's self-esteem by convincing him he has been maltreated. Many maltreated children adapt by rationalizing that their parents care about them and are good parents. Furthermore, the children believe that if they are hit or not fed, it is their fault for being bad. "It is possible that the high rate of poor self-image among victims of abuse may inadvertently be exacerbated by well-meaning professionals. Among child protection workers new to the field, there sometimes exists a tendency to want to say subtly or even directly to the victim, 'Do you know what they did to you was illegal and is child abuse?'" (Weinbach & Curtiss, 1986, p. 344). The sensitive counselor will choose his words carefully and might refer to "strict punishment" rather than "child abuse." It may be necessary to increase a child's awareness of having been victimized in order to prevent further victimization. But the counselor should tread carefully in instances where such revelations or confrontations would further lower the child's self-esteem.

Minimizing the Effect of Trigger Behaviors

There are certain behaviors of children which are distressing to caregivers and which appear to help trigger abusive episodes in an already stressed parent. In order to help the child and reduce the risk of the child provoking further maltreatment, the counselor can determine if specific difficult behaviors of the child may have contributed to maltreatment. The counselor's role in working with the physically aggressive child or the sexually provocative child has been briefly addressed above. The following section discusses the ways in which counselors help minimize risk to the child.

Wetting and Soiling

Wetting and soiling are common issues over which parents seem to lose control. In one study of abuse of foster children by foster parents (McFadden & Ryan, 1986), it was the most frequent behavior leading to maltreatment. It is also a common trigger of maltreatment by the child's family. Obviously, it is important to work with the parent or foster parent around this issue. Providing parent education, developing resources to reduce the work involved, and reframing it from a power struggle to a developmental issue are all parent-oriented interventions. However, the child may also need attention and help.

If all is going well in a child's development, he or she develops sufficient body awareness to anticipate the urge to urinate or defecate around age three. However, it is still normally expectable that a child may occasionally wet the bed until puberty. If all does not go well in the child's development, particularly if he or she is under great stress, the child does not develop normal control of body functions. Some children, when they are sexually or physically abused around the genital or anal area, learn to disconnect from body sensation as a protection from pain and trauma. These children may simply not recognize the urgency of a full bladder or pressure on the rectum. They become anxiously preoccupied with trying to avoid punishment for their mishaps. Such stress creates a vicious circle. Children who lose or lack control of body functions will express feelings in counseling of being frightened, humiliated, and powerless.

Such children can be helped by reassurance and support and by providing experiences that increase their body awareness. They need to understand that other children have had this problem and that it is something which will get better over time. Often, play with water, finger paints, and clay will be useful in gaining a sense of mastery. Children with wetting and soiling problems can be encouraged to take increasing responsibility by learning to wash their own underwear (rather than hiding it), change their sheets, and bathe frequently. They need reassurance that their body products are normal and that they are not "dirty" or "nasty."

Sexualized Behavior

Children who have been sexually abused often develop a repertoire of behaviors which appear to the onlooker to be "sexual" but are actually learned behaviors developed in response to the perpetrator's expectations. It is essential to help the child change the behaviors to avoid future exploitation, but this, too, is a sensitive issue in protecting the child's self-esteem. Younger children particularly learn that such behaviors are "nice" and pleasing to the perpetrator. They are the only way the child knows to get attention.

One of the most important things the sexually abused child learns in counseling is that it was not her fault and that sexual abuse was the adult's responsibility. An overfocus on the seductiveness or inappropriateness of the child's behavior can reinforce the notion in the child's mind that it was indeed her fault, that she has some qualities that are bad and make people behave in a sexual manner with her. The counselor must walk a fine line in helping the child learn new behaviors so that he or she does not end up "blaming the victim."

Foster parents and parents need to know that children who have been sexually abused have a great need for attention and affection, and that as the child's emotional needs are met in appropriate ways, the inappropriate behaviors will diminish.

Masturbation

Another child behavior that triggers parental overreaction is masturbation. Excessive masturbation may be an indicator of sexual abuse, but it can also signify that the child is bored or emotionally needy. While the counselor may wish to use parent education or counseling interventions to help caregivers with this behavior, often the child, too, needs help, particularly the child who has been embarrassed by being "caught" in front of other children. The child should be provided with clear sex education materials appropriate to his or her stage of development (not chronological age). The counselor can indicate that masturbation is a normal behavior but that people do it privately, behind closed doors in the bedroom or bathroom. The counselor can help the child consider alternative activities when he is with other people, such as keeping his hands busy with a toy.

Defiance

The child who does not respond quickly to parental instructions is often perceived as "defiant" or "obstinate." The counselor needs to advocate for psychological, auditory, and neurological evaluation. Blows to the child's head and even shaking by the shoulders can cause damage to the central nervous system, with consequent impaired reflexes, attention span or hearing (Martin, 1976). The child may need help in focusing his attention, while intervention with the caregivers can focus on interpreting the child's condition as being something other than defiance.

Suggested Activities

Maltreated children or youth will usually respond more readily to activities than to "talk counseling." The child is more comfortable when the focus is on the activity rather than directly on him. The counselor's shared participation in the activity demonstrates his or her concern to the child. It also generates a feeling of mutuality and partnership which is therapeutic to the child who has been ignored, rejected, misused or hurt by adult figures. Activities such as games also allow for competition or controlled aggression within limits, further enhancing a child's sense of safety.

Many maltreated children are hyperactive, restless, anxious or distractible. It may be hard to help them focus on an activity for more than a few minutes. The counselor will develop great patience and flexibility adjusting to the tempo of the maltreated child's activity level. Those children who are depressed and withdrawn, on the other hand, may take a whole session to accomplish one task. The counselor is advised to have a "bag of tricks" that can be dipped into when time expands or contracts.

The following are some activities designed to help children with some of their developmental deficits and emotional issues.

Self-Esteem

The child or youth can work on a storybook or scrapbook about himself. It may include pictures, photographs, clever sayings by the child, accomplishments, memorabilia.

The counselor can help the child develop a list of all the good things he has ever done, to be put in the book.

The counselor can work with teachers and caregivers to reward the child for accomplishments of small steps when undertaking a new task.

The child can be encouraged to play with toys and games for a developmental level below his own age, so that success is assured.

The child can keep a record of all the compliments he has received, to be placed in his book.

Body Awareness/Body Image

Physically and sexually abused children often have damaged body images. They associate their body with pain, discomfort or embarrassment. Neglected children have often experienced chronic hunger or the discomfort of dirt and rashes. All maltreated children tend to be less comfortable in their bodies than other children. They may confuse or distort physical sensations. They think they experience hunger when they are actualy experiencing an emotional need or want. They have uncertain control over body functions. Even adolescents may have difficulty with eneuresis or encopresis, particularly if they are feeling extra nervous.

The counselor can engage the child or youth in physical activity, climbing, playing ball, going for a walk, shooting baskets. The counselor models physical awareness, e.g., "I'm hot and sweaty," or "I'm out of breath," or "This feels good." Gently the counselor asks questions to help the child think about body awareness, "Are you warm, too?" "Didn't that hurt you just now?"

The counselor can use several games to help the child become more aware of his senses. The child closes his eyes and is given a lemon to hold in his hand. He is asked to squeeze it, smell it, taste it, rub it, stroke it with his eyes closed. The counselor asks him to describe what the lemon is like, without looking at it.

Another exercise involves giving a child a variety of textures to feel: sandpaper, a feather, velvet, a cotton puff, etc. Talk with the child. Which texture feels the best? The worst? Do the textures feel different if the child touches them with a different part of his body than his hand?

The mirror exercise is a good way for a child to improve awareness of body image. Standing in front of a full length mirror, the child desribes each part of the body and the clothing seen in the mirror.

The child may stand in front of a large piece of paper taped to the wall. Using a bright light to project a silhouette, or simply by tracing, the child and counselor draw the child's outline on the paper. The child then gets to draw in and decorate the lifesize drawing of himself.

Fairness

Children who have been maltreated frequently experience some difficulty in following rules, sharing, controlling aggressive impulses and other tasks requiring superego or moral development. The use of games, from pool to dominoes, helps the child or youth to grasp concepts such as taking turns, playing fair, not cheating, being a good sport. Successful game playing stimulates both moral and social development. The child may try to cheat to see what the counselor will do or get excited at beating the counselor, thus allowing aggression to surface in a controlled manner.

Feelings

Any type of play is the medium for expressing feelings. The child can draw a sad, glad or mad picture. The puppet can talk about loneliness or fear. Music and songs can be a way of learning about feelings.

The use of stories, comics and literature can demonstrate to the child or youth that he is not alone, that other people share the same types of feelings. The counselor can model talking about feelings, and role play with the child or youth how to handle a sad feeling, or how to handle an angry feeling.

Termination

When do maltreated children finish counseling? There are a number of signs we can observe that a child is improving:

- Developmental fixation is unblocked. The child is beginning to move ahead in growth and development.
- The child's physical condition has improved. Nightmares or soiling have decreased or ceased. The appetite is healthy.
- Coordination has improved. The child is no longer clumsy, unaware of body movements.
- School work has improved. The child or youth has energy available to concentrate on learning.
- Behavior has improved. The child no longer exhibits provocative behavior that could cause further maltreatment.
- The child can feel and talk about feelings. The child can cry, laugh, have fun.
- The child has an age appropriate understanding of his situation; e.g., how he came to be in foster care and that it was not his fault he was sexually abused.
- The child has controls on impulses and aggression.

In working with sexually abused children and adolescents, the counselor should keep in mind that the child can only understand her or his situation at the cognitive level at which he or she is currently functioning. Thus a girl may finish counseling at age ten, with a ten-year-old's understanding of what happened to her in a sexual abuse case. She may appear to have resolved the issues, but actually she has placed her concerns on the back burner. She has taken them as far as she can go with the cognitions of a ten-year-old child. Two years later at the onset of puberty, this same child, who seemed to have "adjusted" and "worked through" the sexual experience, may give off a number of distress signals. She may be frightened of menstruation, she may neglect her hygiene, or she may believe she is terribly wounded, and that the blood in her vagina is a result of earlier sexual abuse. In other words, the onset of puberty triggers additional issues or those that may have been beyond her understanding before. It is time for her to resume counseling and reintegrate her experience on a new developmental level. As her cognitive development matures and she gains a capacity for abstract thinking, she will better understand what happened to her when she was younger. It is important to advise the parents--biological, foster or adoptive--of the child's need for future counseling.

Many counselors see the maltreated child's need for counseling to be analogous to the need for health care. A child recovers from an illness and does not need to return right away to see the doctor. But she still will need regular checkups and occasional visits when ill. She may even have a medical crisis for which she would want to return to the doctor. So it is with the maltreated child and the need for counseling. As the child catches up developmentally and moves from stage to stage, there will always be new adaptations and understandings that she or he will want to talk over with a trusted adult. Hopefully, the counselor can be there, as a trusted confidante, from time to time until he or she successfully grows to adulthood.

CHAPTER 6

COUNSELING ABUSED CHILDREN IN GROUPS

Group counseling for abused children is indicated when children have a history of poor social relationships or need confrontation from a peer group (Holder & Mohr, 1981). Corey & Corey (1982) cite a variety of reasons for including a child in a counseling group:

- Excessive fighting
- Inability to get along with peers
- Frequent hurting of other children
- Violation of school rules
- Poor attitude toward school
- Stealing from school or from peers
- Violent or angry outbursts
- Neglected appearance
- Hunger symptoms and/or frequent failure to bring lunch to school
- Chronic tiredness
- Lack of supervision at home
- Excessive truancy (p. 214)

To a child, particularly one who is isolated and afraid, there is comfort in discovering that he or she is not alone, that other children have had similar lives.

There are many types of groups and a variety of activities that can be conducted in children's groups. Psychodrama can be an effective form of therapy, as it involves dramatic acting out of problems in a safe setting. Similarly, with preschoolers and young children, dramatic play such as "The Glum Ghost Who Lives in the Zeon Pit" or "Poor Pity-Me Parrot" can be used to help children handle rage or withdrawal (National Center on Child Abuse and Neglect, 1975).

Very young children do well when involved in developmental play groups (Brody, 1978) or preschool class groups (Parish, 1985). For those youth who have difficulty talking about their feelings, activity or occupational therapy groups can be the treatment of choice. Sports, games and projects such as leather work or ceramics are used as the medium to enable youth to work through their feelings and reach resolution of their problems (Mayhall & Norgard, 1983).

Group counseling is a successful treatment modality for sexually abused girls (Delson & Clark, 1981; Mrazek & Kempe, 1981) and for boys (Nasjeliti, 1980).

Group counseling is especially suitable for adolescents who have been abused or neglected because it facilitates their developmental task of being oriented to peers. Through interaction, adolescents take the opportunity to be instrumental in each other's growth, thus developing feelings of being worthwhile.

Group Counseling of Young Children

Group counseling of young children is usually set within the context of a developmental day care program or as part of group counseling of parents. The focus is on play which can help thaw out frozen developmental processes. Maltreated preschoolers may display random, primitive and chaotic behavior. Typically, they lag developmentally and have difficulty engaging as part of a group. Their participation is much more likely to be parallel play than the actual sharing of a true group experience.

In working with groups of preschool-age children, it is important to have a high ratio of counselors or aides to the number of children present. Maltreated children are less verbal than their "normal" counterparts and will require more time and accessibility to adult nurturing figures to enhance communication. Young children respond better to expressive activities such as working with clay or finger paints. They also need activities which stimulate large muscle development and may involve climbing, expressive movement or action games. An activity used by Brody (1978) with young children in developmental play is "the cradle." The adult nurturer helps the child into a cradle made from a blanket and held by two adults who rock it gently while the rest of the children and adults sing. Such an activity builds trust and helps to provide focused nurturing often not present in the maltreated child's environment. When counseling and caring for abused preschoolers in groups, the counselor can utilize the following suggestions for effective group management of young children:

> **Body Language.** Be aware of body language. An upset adult can still calm a frightened child if the adult's body language is relaxed.
>
> **Positive Phrasing.** Word things positively rather than negatively. This may feel awkward initially and takes some practice. Say, for example,

> "Put your feet on the floor" instead of "Don't stand on the table." This draws the child's attention to what he or she should be doing rather than what is wrong.
>
> **Defining Limits.** Set limits on acceptable behavior by identifying what the child wants to accomplish. Once you know what the child needs or wants, you can help him or her to develop options other than sheer aggression.
>
> **Identify Feelings.** Differentiate between feelings and behavior. You may have to set clear limits on behavior, but always express acceptance of feelings. For example, it helps to say, "I know you're angry and that's OK. Everybody gets angry sometimes, but the sand still stays in the sandbox. It's not OK to throw sand in people's eyes." It is a developmentally important step for children to learn that they can be angry and still control their behavior.
>
> **Words vs. Actions.** Some dilemmas are best handled without words. An effective strategy for a clinging child is to sit down in the middle of the room and make yourself as boring as possible. This is much more effective than trying to leave the child. Threatened with losing you, the child will cling more. Instead, let the child leave you. (Salter, Richardson, & Kairys, 1985, pp. 351-352)

Group counseling of preschool children can be effective in the prevention of sexual abuse. Through the use of stories, songs, and puppet play, children learn basic concepts such as, "My body is my own. No one has a right to touch it without my permission." They also can learn safety rules about both friends and strangers and the types of lures used by child molesters, such as the lost puppy lure, the clown lure, or the "your mother is at the hospital" lure (Wooden, 1985). Other resources include It's My Body (Freeman, 1982) and coloring books for young children, My Feelings (Morgan, 1984), Red-Flag-Green Flag People (Williams, 1980), and It's O.K. To Say No: A Parent-Child Manual for the Protection of Children (Lenett & Crane, 1985).

Activities which enhance self-esteem and sense of self are useful in group counseling with young children. These can range from looking in mirrors, to taking photographs, to drawing one's body outline, or measuring height. Additionally, many of the play activities mentioned in the preceding chapter may be adapted for use in a group with older children.

Group Counseling with Older Children

The counselor is unwise to lead a large group of maltreated children or adolescents alone. One adult can handle no more than three to five children or youth in a group (Corey & Corey, 1982). When there are two counselors involved, they can assist each other with a multitude of diverse tasks in the preparation and planning, and they can support each other in the prevention of chaos and unpredictability in the actual implementation of the group. Additionally, when the team of counselors consists of a male and female member, children of either sex can view role models of the same sex, and an opposite sex adult who is neither abusive nor exploitive. Most maltreated children have had little exposure if any to caring and supportive adults who want or need nothing from them. One of the positive benefits of group counseling is that children and youth are exposed to healthy adults.

There are numerous tasks of group leadership. In preparation for the group, decisions must be made which will affect the life of the group. Will it be a time limited group or an open group in which participants may remain involved until they have finished? What will the location be? Who will be included in the group? What will be the criteria for group membership? What will be the focus of the group? What parental permission will be required? How will the group leaders work with the parents or foster parents? Who will provide transportation?

Corey & Corey (1982) present practical advice on planning groups for children and youth. Avoid "loaded words" such as "sensitivity training" or "therapy." Involve parents. Remember that "the younger the children, the smaller the group and the shorter the duration of the sessions" (pp. 226-227). Prepare carefully for each session and develop an agenda.

Group Composition

In working with maltreated children, it is useful to screen potential candidates and to assess carefully their developmental stage, their needs, and their response patterns to prior maltreatment. Some children adapt to maltreatment by withdrawing or becoming compliant. Others develop fairly complex patterns of aggression. One does not wish to form a group composed of all aggressive children or youth. Nor does one wish to have a group composed solely of quiet, apathetic and withdrawn members. Ideally, when forming the group, several children or youth should be included who have some social interaction skills and who can model more normal or appropriate behavior to other group members. With one exception, it is not necessary that all children or youth have experienced the same type or degree of maltreatment. The exception is that in groups for sexually abused children, all group members should have been sexually abused or exploited. In counseling sexually abused youth, the group should be composed of all members of the same sex, although it is useful to have both male and female group leaders for the reasons discussed above.

When developing the list of group members, it is important to look at the developmental stages rather than the exact chronological ages. One guideline for assessing the developmental stage of adolescents is to ascertain the age of the youth at the onset of maltreatment. For those youth whose maltreatment was severe and began early in childhood, development is likely to be fixated around the developmental stage attained by the onset of maltreatment. For example, a youth chronologically 15 might be emotionally arrested at around age six years. Their issues are usually lack of basic trust, enormous emotional neediness, and often self-destructive or aggressive behaviors. Youth who experienced a qualitative shift from harsh discipline in earlier childhood to actual abuse at the onset of adolescence are more likely to have attained a pre- or early adolescent stage of development. Their issues are typically difficulty with close relationships and rebellious behaviors such as truancy or running away. A few maltreated adolescents had a relatively conflict-free childhood and early pubescence, and were not abused or neglected until they had attained a full-adolescent developmental status. In such cases, often the youth's strivings for autonomy precipitated a conflict with parents struggling with the equally vexing developmental issues of middle age. This third type of adolescent is the only one of the groups mentioned above to have the normal "adolescent issues," because the type represents only those youth who had a normal childhood (Ziefert, 1984). It is important to assess the developmental stage of adolescents and to plan group composition and activities to meet the needs of this particular stage. If the counselor keys in on developmental stage rather than chronological age, it will be helpful in determining who should be in the group and what the group may be capable of accomplishing.

Involvement of Parents

In counseling groups of children or adolescents it is usually necessary to obtain the permission and cooperation of parents. If the group members are foster children, it will also be important to involve the caseworker and foster parents in planning. Some of the key issues are attendance, transportation, name and purpose of the group. With social workers and foster parents, the counselor can be fairly straightforward about describing the group as being a treatment resource for maltreated children. With biological parents, particularly where there has been no intervention, the counselor must be diplomatic. For obvious reasons, names such as "Youth Goals Group" or "Girls Afterschool Activity Group" are less threatening than any name which might even indirectly refer to maltreatment.

Particularly with younger children, transportation can be an issue unless the group is held during school hours. Involving the parents in car pools or parent coffee hours may be one way of solving transportation problems. If transportation is to be provided as part of the group service, the counselor should check his or her auto insurance carefully and should have a written request or consent from the parents. The counselor should also be aware when transporting children under any circumstances that many children who have been sexually abused were first approached when alone in a car with an adult. Thus, riding in the counselor's car could be a very anxiety-provoking experience for the child, who could conceivably construe a casual gesture of concern or liking as a sexual invitation. However, many children and youth find that riding in a car with the counselor is a safe time to communicate and open up. The counselor must use sensitivity and discretion in transportation decisions.

Another way of involving parents is to ask for their concerns or assessments of the child's or youth's needs and how the group activities could be helpful to their child. Even inadequate parents like to be recognized as the "experts" on their offspring and will respond favorably to the counselor's interest in their opinions.

It is important to clarify the concept of confidentiality with parents. The counselor will not be reporting to parents on specific information the child or youth brings up in group. Neither will the counselor be sharing with outsiders (teachers, social workers, etc.) the specific content of a group. If the counselor is utilizing supervision or consultation, it is appropriate to mention that things happening in the group will be discussed with a professional colleague.

Parents need to understand the boundaries which will affect their child within the group. The counselor should advise of the basic group norms and limits and the circumstances under which a participant might be excluded (failure to attend, violence, etc.). The counselor should also find a way to let parents know that "discipline" in the group will be handled by the counselors and that parents are not responsible for disciplining the child for anything which may occur in the group.

Group Norms

Part of the process of group formation is the group members' participation in developing norms which will facilitate group interaction. In many groups with children and youth, the counselors can initially involve the participants in the process of suggesting and reaching consensus on group norms. However, with maltreated children and youth, the counselors must put first things first. The top priority is establishing clear limits before the group ever gets off the ground. Usually the fewer the rules the better. But what rules do exist must be crystal clear and consistently enforced. Typical limits in a group of maltreated children or youth involve physical and emotional safety. No one hurts anyone else. I won't hurt you, and I don't let you hurt me. Other rules about use of the physical environment need to be made explicit. One group in a treatment facility had to develop a rule "no hanging from the pipes" (Clifford & Cross, 1980).

Many counseling manuals stress the importance of confidentiality with children and youth. When working with maltreated children, however, the counselor should always remain cognizant of the limitations of confidentiality. Child abuse must be reported. Suicide must be prevented. Threats to public safety must be stopped. Therefore, the counselor should never imply total secrecy, but rather should focus, if this is indeed the case, on the children's responsibility not to gossip outside the group. The counselor can also inform the children that parents know that what goes on in the group won't be reported back to the parents. It is up to each child to decide how much he or she wishes to share at home.

The time boundaries should be clarified with children and youth. Most maltreated children are unable to focus or pay attention for more than one-and-one-half or two hours. Beyond that time frame they are likely to grow restless and group processes may deteriorate. Prompt beginnings and clear endings help to structure time for those children who have come from a chaotic and dysfunctional situation.

When working with adolescents it is important to establish clear limits prohibiting any drug use or attendance when under the influence of alcohol or substances. Smoking should not be allowed in groups as it is a health hazard and serves as a diversionary tactic to avoid painful feelings.

Once group limits have been established and the rudiments of group cohesion are evolving, the counselor can help the group arrive at some consensual norms. Due to developmental lags, and internalization of unsocialized or antisocial behavior, maltreated children or adolescents may have difficulty operationalizing such norms as "sharing" and "taking turns." Many maltreated children parrot the verbal abuse they have received in their social interactions, or their low self-esteems becomes evident in the names they call themselves as well as others. If the group cannot establish a norm prohibiting "the dozens" or "put downs," it may be important for the counselors to establish such a limit.

Groups of maltreated children can be volatile. The author has seen adolescents regress in the presence of refreshments and gorge or fight over the food. One minute two youth can be working intently side by side (in the adolescent equivalent of parallel play), and the next moment an inadvertent remark can cause a conflagration of angry behaviors and words. With both children and teens it can be useful to allow brief time-out periods to a group member who seems to be losing control. The counselors should remind each other that such children, feeling unworthy and unloveable, consistently and repeatedly set themselves up to be rejected or to continue the intricately complex interactional patterns of abuse. The counselor should firmly resist two sets of temptation; i.e., to overlook violations of limits because the children are so needy, or to react in a peremptory manner to children and youth who are difficult, demanding and often challenging to the counselor's notion of what is appropriate behavior for that age.

Maltreated children typically have had very few outside controls as in the case of neglect, or inconsistent or excessively punitive controls as in the case of abuse. In either case, the child or youth has not had an opportunity to internalize controls and move toward a position of self-discipline. Thus, the whole issue of norms and limits is paramount in group work with abused children.

Group Activities

When planning group activities for maltreated children, it is important to keep several things in mind. First, they need assistance in the affective-emotive realm in opening up and expressing feelings which are frightening. Equally important is the idea that these are first and foremost children, with all the needs of children everywhere, and that a narrow focus on maltreatment denies them the opportunity for expansion of interests and self-esteem. Another significant issue the counselor should keep in mind is that typically maltreated children have less verbal accessibility than other children, so that typical "talking therapy" approaches are less effective. In a well-structured group, activities should be available, over the life span of the group, that can enhance the child's or youth's development in all of the developmental areas discussed earlier: social, emotional, moral, cognitive and physical. Many activities combine several developmental spheres. Modeling clay can be used to express feelings and release motor tension, thus enhancing physical coordination. Talking about the figure modeled can promote social development. Refraining from smashing someone else's clay figure is an achievement of moral development.

There are many forms of drama therapy, psychodrama or role play that can be helpful for youth and children. "As with action, taking roles is a core aspect of drama. These roles may be close to home (one's self or others) or may be distant, even abstract (animals, machines, aspects or nature, etc.). Children playing themselves, mommy, doctor, monster or spaceship; adults taking the role of spouse, victim, attacker or the feeling that 'blocks' them--all these roles convey information and carry feeling. In therapy, these self and other representations can be enacted and reflected upon as individuals work toward the integration of the personality in a meaningful way" (Irwin, 1986, p. 350). In the author's work, counseling maltreated children in groups, drama has been used in some of the following ways:

> **"The Magic Shop."** A group of latency age children enacted a drama in which they could approach a kindly magician who could grant them whatever quality they needed. Some asked for protection, others asked for adventure, love and other abstract qualities. The children then played out how they would use the quality which had been granted.

Puppet plays. Puppet plays have been used by young and older school-age children to play out issues of aggression, conflict, fears, etc. Children often enjoy enacting fairy tales which deal with themes of maltreatment or victimization (Hansel and Gretel, Little Red Riding Hood) or transformations (The Ugly Duckling or Cinderella). They will also enact episodes of TV shows which may have been frightening. A sense of mastery is gained by developing endings in which the protagonist experiences greater degrees of mastery over fearful or painful episodes.

Role plays. Adolescents particularly love the opportunity to act out roles of other people. Youth in foster homes, for example, experience great hilarity and great thoughtfulness by playing parts of the judge, their social worker, or their foster parents. Role play also provides an opportunity to do behavioral rehearsals of approaching challenges. Youth enjoy role playing issues such as leaving for independent living, conducting a job interview, or resisting sexual exploitation.

Video plays. Adolescents respond favorably to the use of a video recorder to capture reflections of dramatic play. The camera is a source of nonjudgmental feedback which makes them feel important. Seeing oneself on TV can dispel negative self-image and develop at least the rudiments of an observing ego.

Bibliotherapy can be useful in counseling groups with children and youth of all ages. The books should be selected carefully to fit the developmental stages and emotional issues of group participants. There are a number of quality books in circulation which deal with the issues relevant to maltreated children (Belcher, 1985; Dreyer, 1977). There are a variety of ways to utilize books in the counseling process:

With older children and youth, books can be distributed for reading outside of group and in group discussion. There are several cautionary notes. First, the counselor should ascertain that all children are capable of reading--many maltreated children have minimal brain dysfunction, learning disabilities and general developmental lag in the cognitive sphere. The counselor should also ascertain if the child has a place in which to read, and that the parents would not be angered by the presence of such reading material.

> Particularly with younger children, the counselor can read exerpts of a book while the children rest or play quietly. It is often a good idea to give the children a task they can do quietly (drawing, eating a piece of fruit) during the reading, as it is a major challenge for maltreated children to sit still for any extended period of time.
>
> With older children and adolescents, group members can take turns reading a story. The counselor should be sensitive to the fact that some youth cannot read well or may have experienced humiliation in school when unable to do a reading assignment. The use of volunteers from the group is recommended.
>
> Use of films and video stories geared to the youth's needs is recommended, particularly when the group contains nonreaders. Foster children enjoy "Pinballs," a Walt Disney made-for-TV special, which is the story of a young adolescent girl, a 12-year-old boy in a wheelchair, and a five-year-old boy placed together in a foster home. The children in the film struggle with issues such as feelings toward the parents who hurt them, feelings of powerlessness, and learning to care for each other.

Art therapy is useful with children and youth of all ages and developmental stages. It allows for the safe expression of powerful feelings. It also can create a soothing climate in which all children or youth are involved in the creative process, doing a type of parallel play rather than the more threatening social interaction. In groups designed specifically for victims of sexual assault, exercises such as drawing the offender or drawing the setting in which the assault occurred are especially effective (Mayer, 1983). Even preschoolers who have been sexually abused benefit from expressing or describing the incident through coloring or finger painting. The use of clay is popular with all ages.

There are essentially two ways in which artistic expression can be used in a group. The first involves a "parallel play" situation when each individual is engrossed in his or her own creation. This is useful with younger children, or adolescents who have been developmentally fixated at younger levels. Group art projects, such as collaborating on a mural or working together on a mandala, require that the group participants have social interactive skills which will permit collaboration. Often in the course of a group, the counselor will begin with a series of individual projects and, as the group develops cohesion and trust, move gently to collaborative group projects. The counselor will find the content of children's drawings useful in the diagnostic process. The size of the image drawn is highly significant and provides a measure of the subject's self-esteem. The amount of detail can suggest a child's awareness of the external world or deficits in the child's self-image (Wohl & Kaufman, 1986). The author has found that "messy" art work seems to be useful to children dealing with eneuresis and encopresis. One boy who had trouble with soiling spent weeks finger painting in shades of brown saying, "Oh boy, nasty gooey." Shortly after starting to fingerpaint he stopped soiling.

While drama and art seem to be the media of choice for helping children express buried feelings, there are many group exercises which develop strengths in the social and moral development domain. Thayer's (1976, 1981) sourcebooks on affective education provide many activities which encourage group examination of emotional and moral issues and can be adapted for less mature children and youth. The author has found values clarification exercises to be popular with maltreated adolescents, who are struggling to make choices and internalize controls. Using a basic values clarification format, in which all stand on either side of an imaginary line, and making forced-choice decisions by moving to one side of the line or the other, a number of issues can be explored:

- Personal taste. A series of about 20 preferences can be developed; e.g., I prefer pizza vs. I prefer ice cream, or I prefer soul music vs. I prefer reggae.
- Preparation for independence items can be developed; e.g., I would rather take with me a first aid kit vs. a map, or I would rather live alone vs. I would rather live with a friend.
- Moral choices can include items such as it is more important to help a friend in trouble vs. it is more important to keep a promise and arrive somewhere on time.

The youth enjoy seeing the choices made by other group members, and they enjoy the opportunity to physically move about. These value clarification exercises are often the stimulus to penetrating group discussion about individual differences and social conformity.

Many maltreated children have experienced only severely constricted social and physical environments. Their sense of possibility or potentiality may be cripplingly limited by a fear of venturing forth into the unknown. Additionally, they may never have learned how to play or make constructive use of leisure. Thus, the gamut of field trips and leisure activities are useful in a counseling group. With younger children a trip to the zoo may stimulate all sorts of discussion about what is one's favorite animal and a wide range of dramatic play about animal situations. With older children and adolescents, selective exploration of community resources can promote a sense of belonging or well-being. It is especially important to remember in group counseling situations that participants need to grow in a number of dimensions and that a broad focus on building competence transcends the narrow issue of addressing the child's feelings about himself and the maltreatment.

Special Problems and Issues

Counselors leading groups of maltreated children and youth should be alert to notice the dysfunctional group process of scapegoating and try to deal with it before it begins to consume the group. In any group of maltreated children there will probably be several who have acquired a significant repertoire of maladaptive behaviors which bring about rejection or aggression. Arvanian (American Humane, 1976) describes a scapegoating process in a group of adolescent girls in which an overweight and slightly retarded girl began clinging to the group leaders and the other group members began joking and teasing her. The more she clung, the more the group teased. The group leaders were placed in the difficult position of having to "reject" her by not allowing clinging in order to help her be incorporated into the group. As the group dealt with the scapegoating problem, group members were able to reclaim and own their anxieties which they had projected on the scapegoat. All group members felt relieved and protected that the group leaders stopped the scapegoating.

In groups of maltreated children there may often be several members with poor personal hygiene. These problems may range from a child whose body and clothes are filthy to a child whose clothes reek of excrement. The counselor needs to be aware that the child may accept his or her condition as "normal," that in a neglect situation the child may have no access to showers, washing machines and other hygiene-promoting technology. If the situation is one in which there is clearly parental neglect, the counselor would need to contact protective services. However, this type of situation is rarely so clearcut. On the one hand, the counselor must protect the child from scapegoating and rejection by the group, and on the other hand, the counselor must begin to assess the reasons for the poor hygiene. A group activity on personal grooming may be a way to elicit information or responses from the child. In the case of adolescents, the situation may be a statement or expression of a certain "political or philosophical" position. It is advantageous both to let the youth explore his reasons and to facilitate feedback and understanding from the rest of the group. Direct confrontation is rarely effective. One hypothesis the counselor should consider is that the child or youth has an emotional need for distance from other people, and the poor hygiene and body smells are quite functional in maintaining what is felt to be a "safe" distance. Many children who have been sexually abused will use these techniques to protect themselves from appearing "desirable" to adults.

In a group in which members are particularly needy, it is not unusual to find that children and youth who are verbal--in contrast to most of the other children--may be so greedy for the spotlight that they will ramble and monopolize the group's time. When the counselor notices some of the other group members tuning out in boredom, or acting out disruptively, the counselor can check with the group. "I'd like to stop for a moment to check out your reactions to Betty and to find out where you are at this moment" (Corey & Corey, 1982, p. 242). The feedback teaches group members to use time more productively. One can also help the rambling monopolizer by saying that the story has been long, and you would like to hear the speaker summarize the point of it in one or two sentences.

In addition to the sort of anxious activity and aggression that erupts in a group when topics get painful, the counselor can also expect at times that the group may be very lethargic and apathetic. Typically, this flat affect occurs when group members are experiencing the futility or depressing aspects of their situation. Many maltreated youth have learned to choke back anger and turn it inward rather than risk exposing it to an adult who may be potentially dangerous or rejecting. A comment on the emotional climate of the group, e.g., "I notice no one has much energy tonight," and a go-round to allow each member to state why he is quiet, what he wants from the group, and what he is willing to do about it may help to enliven the flat affect. It is important to keep in mind that maltreated children often have chronic or profound depressive tendencies, due to feelings of being unloved or the dynamic of turning anger inward. They are also subject to reactive depression when they are separated from their parents or are preparing for emancipation from foster homes to an uncertain future. In many instances, once the child begins to release some anger through the counseling group, the depression or even despair may start to surface.

In planning the length of the group and thinking about termination of the helping relationship, counselors should keep several complex factors in mind:

- In brief, time-limited groups, children may develop less dependency than in longer, ongoing groups.
- Many youth in the group will have enormous unmet dependency needs.
- Termination of the group may consciously or unconsciously recapitulate for the child earlier, unresolved issues of loss and separation.
- Depending on the severity of the trauma, and the child's stage of development at the time of the trauma, the child or youth may need far more extensive treatment than can be found in a counseling group.
- Counseling groups basically utilize the social interaction with peers as the medium for growth. If a child is observably emotionally needy or impaired, referral to longer-term individual therapy may be indicated.
- In completing the counseling group, the counselor should take particular pains to ensure that each child has an ongoing support system of concerned adults and/or peers.
- The counselor should attempt to clarify with youth the meanings of their expressions of sadness. Is it situational and specific to the closure of the group experience? Or is it a red flag of severe or suicidal depression?
- The counselor should be aware that as long as maltreated youth are attending a group, they do have a vehicle through which to ask for help if the situation gets bad at home. Before termination, the counselors should check with the group and ensure that each child would know how to ask for help if he or she were in serious difficulty.

Many counselors find that as part of the termination process it is helpful to invite parents in to meet with the group. If this occurs, it is important that children and youth see that the counselor respects the agreed-upon boundaries of confidentiality and does not "gossip" with parents about their children. The children or youth should be enabled to act as hosts and hostesses for their parents. There should be a clearly structured focus. Either the occasion is a social hour, or the group participants have carefully planned a role play or other piece of entertainment or communication for the event.

After working with a group of hurting children, the counselor may find it difficult to approach the parents in a nonjudgmental and caring manner. Throughout the process of working with abused children and their families, the counselor must seek a consistently high level of self-awareness. Such professional development strategies as studying one's own family of origin, joining a professional support group, or seeking supervision or consultation can assist the counselor in handling the overwhelming feelings which may emerge. In the next chapter, counseling the child's parents will be explored. Despite all the counselor's best efforts in behalf of the child, little long-term change can occur, and the child's safety cannot be ensured unless the parents are helped.

In understanding both the strengths and limitations of group counseling with maltreated children, it is useful to know research findings about the later development of abused children. Elmer & Martin (1986) state, "Individuals may react differently to early trauma, not only because they tend to use different coping strategies, but also because different life events affect their perceptions of themselves and others and teach them varying ways to respond" (p. 8). According to Steele (1986), "It should be remembered that abuse is not the only thing that happens in the lives of these children. Many other events have significant influence on the child's development. There may be other either nurturant or destructive figures in the child's life--relatives, school teachers, ministers and friends--who can alter the growing child's psychic development" (p. 284).

The group can be a benign social laboratory which brings the child to new experience, admits sunshine into the closed room of his existence, and teaches him that people care and can get along.

CHAPTER 7
COUNSELING ABUSIVE PARENTS

Self-Awareness

Whether the parents have physically or emotionally abused their children, or neglected or sexually abused them, the counselor will have to struggle with a number of feelings to reach a dispassionate stance. One's own values and standards about child-rearing and discipline come into play. A small voice whispers inside, "How could they do this to a child?" The counselor knows the theory and research about maltreatment and can cite a list of reasons, intellectualizing beyond the discomfort. However, to reach the point of empathy and caring where one is truly helpful in a counseling relationship, the counselor must move beyond the defenses and be willing to walk for a while with the client's pain. Dealing with sexual abuse seems to be the most demanding task for counselors. Justice and Justice (1979) advise, "We must be certain when we begin work with an incestuous family that we are not holding on to any outrage or letting the feeling cover our own repressed sexual feelings. We must be equally careful to avoid the other extreme of rationalizing the behavior of the incestuous parent, e.g., He couldn't help it. He had all these pressures on him. What do you expect since he had poor parenting and his wife was so rejecting? Rationalizations serve the same function as outrage in defending a person against unacceptable feelings toward his or her own children" (p. 243).

What we face in dealing with abuse is a disturbing reminder of our own conflicts and inadequacies. All parents have some sensual or sexual feelings about their children, but suppress and do not act on them. When dealing with physical abuse, we are nervously aware of moments of anger with our children. In examining emotional abuse, we painfully recall the times we said unkind or hurtful things to our children. Although most counselors cannot identify with the type of neglect in which children are not fed, sheltered, bathed or clothed, many counselors have second thoughts about their own professional busy-ness, the frenetic quality of life which never quite allows the hoped-for amount of time, and the times of burn-out, depression or fatigue when there is little left to give to the family.

As knowledgeable professionals, counselors sometimes know too many of the pitfalls of parenting for their own good. The static generated by tuning into an abusive situation can wreak havoc in the counselor's feelings about his or her own parenting. One of the most effective preparations for counseling abusive parents is the careful examination of one's own issues in the family of origin and in the family of procreation. In order to avoid emotional static and the potential for either punitive overreaction or denial, the counselor can make use of supervision, consultation or a professional peer support group.

The earlier child abuse literature gives examples of the massive denial of maltreatment by professionals. Emergency room physicians believed the child had fallen out of the high chair. Therapists and counselors could not hear or respond to the not so subtle hints given by parents. Jolly K., the founder of Parents Anonymous, told professionals that she was afraid of hitting her child or hurting him. Professionals provided premature reassurance with vague statements that many parents have some angry feelings toward their children. She was not heard and had to abuse her child in the waiting room of a child guidance clinic in front of horrified staff before the counselor could acknowledge her abuse problem. With several decades of public awareness and media attention to the problems, counselors are now aware that abuse exists. However, it requires great self-awareness and self-discipline to know that abuse has happened with this parent whom we are seeing. Many of the counselor's defenses are working as armor against the painful reality of maltreatment. The counselor needs specifically focused training in order to know what questions to ask to bring into the open the complex issues of maltreatment.

For all of these reasons, it is important to remember that developing greater self-awareness and greater knowledge are the most important parts of preparation for the counseling relationship with abusive parents.

Safety of the Children

Before beginning a counseling relationship, whether with individuals, couples, or group members, it is necessary for the counselor to be clear about the kinds of external controls that are in place to prevent parents from harming their children. Parents who are under protective service supervision with children remaining in the home have one sort of external control. Parents under court jurisdiction or on a suspended sentence have more stringent controls. Parents whose children have been removed are in yet another situation. The counselor may work with parents who have no outside authority involved. Counseling alone cannot keep children safe (Cohn, 1979). If there are parents of unprotected children in individual or group counseling, the counselor will have to be extremely careful with counseling techniques so as to not stir up additional rage in a client which could boomerang onto the child.

The Initial Session

There are basically two types of situations with abusive parents in which counselors find themselves. The first is one in which the counselor has had no prior knowledge of maltreatment, and the parents reveal it in the confines of the counseling session as a trusting relationship develops. The second type is the situation in which the counselor has prior knowledge of the abuse. The counselor should handle this prior knowledge carefully so as not to set up traps for the clients. Most people, before they have established a relationship of trust, will deny deviant behavior when speaking with a stranger. Thus, if the counselor knows that the child has broken ribs and healing fractures, the counselor should not play games with the clients. Information and the source of the information should be shared with the client (Compton & Galaway, 1979).

The counselor will need great skill in handling the emotionally laden initial interview. In Goldberg's (1975) words, "The parent is upset, whether wracked by guilt for having injured the child, shame for having lost control of himself, or embarrassment about having his 'inadequacy' exposed. The parent fears the legal or psychiatric consequences of child abuse, the degradation ceremony through which his social identity is lowered, the rite of transition from a normal position in society to a deviant role" (p. 274).

The literature suggests that parents who maltreat children often have a host of problems with self-esteem and are fearful of rejection (Helfer & Kempe, 1976; Otto & Brown, 1975). The situation is volatile as the counselor struggles to rise above feelings of anger about the harm done to the children and to reach out in a helpful way to the parents. If the counselor's body language or inflections reveal the inner struggle, the parent may shut down all lines of communication. It is important that the counselor neither blame nor confront the parent. The counselor's job is not to obtain a confession (Trainor, 1983). Rather, the counselor's role is to bridge the communication barriers which separate the clients from getting help.

The parents will respond negatively to an intrusive posture by the counselor. Goldberg (1975) recommends positioning the counselor's and client's chairs at a 60 degree angle, not side by side, and not face to face. Such an arrangement eliminates the confrontive amount of eye contact in a face-to-face arrangement. It allows the parent to talk without looking directly at the counselor. It is also important not to get the seats too close to each other, but to allow two to three feet distance between. This allows the parent to feel his own space is protected, but it is also close enough to signal that this is a personal communication. It is best to sit with the parents, not behind a desk which is a barrier in a literal sense and also in a psychological sense.

Maltreating parents often do not express emotion in early stages of the counseling process. Their affect may be very bland, depressive or controlled. The counselor can assist the parents by "reaching for feelings" (Goldberg, 1975). Questioning a parent about, "How do you feel about this?" is generally ineffective. It can create a more defensive response from the parent, or can alienate the parent who feels that the counselor is violating privacy. Reaching for feelings can be described and understood as the counselor's reflection back to the clients of their body language, e.g., "You are frowning and your hand is shaking," or the counselor's empathic responses such as, "That can be really frightening." Such techniques of empathy and reflection can assist the parent who appears unable to express any feeling, or is displaying affect that is clearly inappropriate to the situation. After the counselor reaches for feelings, a comfortable silence and waiting period should allow the parent to process what is happening inside. The counselor's understanding responses should enable the parent to open up as trust develops.

Exploration with the Parents

As rapport develops, the counselor helps the parents to explore a multitude of factors. An eco-map (Hartman, 1978; Hartman & Laird, 1983) is useful in objectifying the life stresses on the abusive parents. It portrays graphically the resources, connections and stresses interacting with the family. Often, after examining one's situation through the ecological map, a parent will remark, "Oh, all of a sudden I can see just how much pressure I was under," or, "No wonder I lost it. I was giving to everybody, and there was nothing coming back in for me." As isolation and gaps in resources are identified, the counselor should take action to contact those agencies and programs which could provide the supportive services.

In exploring the client's feelings and the situations which led up to the maltreatment, it is helpful to be sensitive to issues of vocabulary. Many of the terms connected with child maltreatment are harsh, e.g., beat, neglect, abuse, molest. The client may have trouble applying these harsh and condemnatory phrases to himself. If the counselor can substitute less pejorative terms, e.g., lose control, have an angry episode, feel attraction to, etc., the client will feel freer to open up and less judged by the counselor.

When counseling with abusive parents, the counselor should advocate for or facilitate proper health care and communicate with the doctor to assess whether physical health problems are related to the loss of control. There is some indication that physical problems such as neurological disorders, blood sugar levels, premenstrual syndrome, and severe headaches make it more difficult for parents to remain in control of their feelings and actions. Certainly in neglect situations parents are often in poor physical health, which limits their ability to care for the children. Other disturbances, such as post-traumatic stress syndrome, depressions, psychoses and addictions, should also be medically evaluated.

One of the issues to be explored is whether the parents connect their feelings with their behaviors. Often a great deal of denial or suppression distorts their perception of abusive behaviors. Similarly, some parents lose awareness that their behavior results from feelings that have run amok. A parent will report, "Suddenly I came to my senses and realized that I had my hands around my daughter's throat. I don't know why I did it," or "I felt as if I had gone outside of myself. I didn't mean to hurt him. It started out as a spanking and something snapped in me." Upon exploration, parents can begin to identify the thoughts and feelings which led to the loss of control and become ready to utilize intervention techniques which leave them more in charge of thoughts, feelings and actions (Otto & Brown, 1985).

Conger suggests that a primary goal of the therapist is to help create in the lives of abusive parents the same personal and social controls that inhibit violence in other families. Some of these controls are positive contacts with the children rather than completely negative interactions, being in a social network, being attached to others, and receiving payoffs from conventional activities which preclude deviant activities (Conger, 1982). The counselor should explore with the parents the potential activities, relationships and resources which might help the parents see themselves in a more responsible and less deviant way. For example, one abusive mother was helped by joining a bowling team and a reading class for her learning disability. She stated, "Bowling was fun. I hadn't ever had much fun in my life. It gave me a safe way to let out my anger. When I had a bad day, I could really heave that ball down the alley. When the ball hit the pins and there was that big crash, I felt relieved. I could bitch about my kids with the other mothers instead of hitting the kids. When I learned to read I felt like a different person. I had gone through 12 years of school thinking I was dumb and stupid. No one ever told me I had a learning disability. Now that I can read, I feel so much more in control of my life and like I can be a normal person. I have people who care about me and I can't let them down, or let myself and my kids down."

Exploring with the parents the events of their childhoods can be helpful in some cases. It is especially important to help the parents identify the examples, messages, and scripts set for them by their own parents which connect to their actions with their children in the here and now. The counselor will want to sort out how identified the parent is with his own maltreating parents. If a parent says, "My mama raised me with a belt and a board, but she was right. I was a bad kid and I needed it," the parent is using the defense mechamism of identification with the aggressor and will often have more difficulty in wanting to change punitive behavior. On the other hand, if the parent says, "My parents beat me, and I didn't like it, and I vowed I'd never do that to my kids. I feel so guilty," the parent's cooperation may be more immediately accessible.

Other areas of exploration are the parents' fantasies and expectations about counseling, and their feelings of hopefulness that counseling can help them change.

Approaches to Counseling

There is a wide range of counseling techniques and therapeutic strategies which will work with abusive parents. The bibliography of this monograph lists many publications on the treatment of parents. It is not within the scope of this monograph to explore all treatment approaches or intervention strategies. Rather, the reader is advised to peruse the wealth of material already in print on working with parents.

When counseling abusive parents, the development of insight is not enough (Otto & Brown, 1985). The focus needs to be on changing parent-child interactions (Helfer & Kempe, 1976). If physical abuse is stopped, it may be replaced by emotional or verbal abuse (Otto & Brown, 1985). Counseling has limitations as a treatment strategy. A mixed model with a variety of approaches is useful in the treatment of physical abuse (Helfer & Kempe, 1976) and sexual abuse (Dixon & Jenkins, 1981). Such a mixed model might combine counseling with a parent aide and a parent support group on physical abuse. In incest situations, the treatment may be sequenced in the following order (Giaretto, 1981):

1. individual counseling for child, mother, father
2. mother-daughter counseling
3. marital counseling if the family wishes to be reunited
4. father-daughter counseling
5. family counseling
6. group counseling

In neglect situations, the counseling may have to be carried out in the client's home, through aggressive outreach to a poorly functioning client (Trainor, 1983).

Many types of groups have proved useful for maltreating parents. The Parents Anonymous and Parents United groups are self-help groups in which members form supportive helping networks. Group counseling can also serve as a vehicle for parent education efforts to teach parents age-appropriate expectations for their children (Otto & Brown, 1985), effective discipline techniques (Ryan, 1984), and ways to manage their own anger (Nomellini & Katz, 1983). High risk infants and children can be served in a group setting with their parents, in which the parents are encouraged to observe and play with their children and to watch videotapes of their interactions (Phillips, Gorman, & Bodenheimer, 1981). As social isolation is a key issue for many abusive parents, group counseling can be particularly effective in meeting the parents' needs for supportive contact.

Behavioral interventions, whether with individuals or groups, have been empirically demonstrated to be effective. Some techniques which have been developed are as follows (Isaacs, 1982):

- teaching parents to use positive reinforcement
- teaching parents to identify and record child behaviors
- teaching parents to use "time out"
- teaching parents to contract with their children
- teaching parents to set up a token system
- teaching parents to redirect child's aggression
- teaching parents to provide differential attention

Other techniques used for anger control involve teaching parents about anger, teaching them techniques of self-monitoring, relaxation and self-reinforcement, and providing an opportunity to practice in simulated conditions. Some steps in this process include (Nomellini & Katz, 1983):

- pinpointing things that make parents angry
- identifying antecedents to angry responses
- keeping a diary of anger experiences
- learning muscle relaxation or deep breathing exercises
- using self-instruction to cope with anger on a cognitive level and to reappraise anger situations in less upsetting ways
- coping with anger on a behavioral level by expressing anger assertively rather than aggressively
- developing a hierarchy of troublesome situations and roleplaying them to utilize newly acquired skills

Family therapy is often used in physical and sexual abuse situations. The family is viewed as a system in which the maltreatment of the child functions to maintain the system. In other words, the abuse is not so much the problem as it is the solution to the problems of a dysfunctional system. Minuchin (1978) and Hartman and Laird (1983) address in great depth both the concepts of family systems and the methods of working with multiproblem families in which children are maltreated. In family therapy the counselor may work with the entire family at once or with various subsystems within the family.

Psychoanalytically oriented therapy is not the treatment of choice in abusive situations. On a practical level it is time consuming and often enormously expensive. Steele (1976) believes that both the life style and the character structure of most abusive parents make a psychoanalytically oriented approach impractical.

Transactional Analysis and Gestalt techniques have been used in work with maltreating families. Justice and Justice (1976) have worked with concepts of parent, adult, and child ego states, giving and receiving strokes, and script analysis, with physically abusive families. In Born to Win James and Jongeward (1976) detail a great variety of exercises to help people come to terms with the life scripts developed from inadequate or abusive parenting.

A feminist approach to counseling with abusive families would examine the uses and abuses of power within the family. It would also redefine the role of the mother if the father was the physical or sexual abuser. In the earlier literature, there are many comments about the spouse consciously or unconsciously colluding in the maltreatment. According to Wattenberg (1985) "The feminist perspective brings into the focus the extraordinary power that is exerted by the father as perpetrator (in sexual abuse) not only holding the economic balance of power in partriarchal family systems, but in controlling the level of threat to both mother and daughter should they dare to expose this deeply abhorrent family secret. The assumption that mothers have accepted the price to be paid--silence and complicity--in the face of the father's assault on their daughters in return for economic or personal safety, is incorrect. What emerges from viewing the family roles through the prism of patriarchy is a range of behaviors and profiles of mothers in various conditions of impaired functioning" (p. 207). If mothers are disabled, terrorized, hospitalized, battered and so forth, it raises quite different implications for counseling than would the belief that mother was colluding with the perpetrator. A feminist perspective on counseling would focus more on empowering both mother and daughter than on developing insight or expressing feelings.

When Do We Know the Child Is Safe?

One of the overwhelming concerns in counseling abusive parents is how and when to make the determination that counseling has been effective, and that enough controls and supports are in place to ensure the child's safety. In the treatment of physical abuse, Beezley, Martin and Alexander (in Helfer & Kempe, 1976) recommend the following criteria:

- The parents can find joy for themselves, including mutual sexual satisfaction.
- The parents see the child as an individual rather than as a need satisfying object or an extension of the parents.
- The parents enjoy and take pleasure from the child.
- Expectations for the child are age appropriate.
- The parents have the ability to tolerate the child's negative behavior.
- The parents can allow the child to receive emotional rewards from people outside the family.
- The parents are comfortable about expressing positive affects to the child. (pp. 188-189)

When considering a termination of counseling in sexually abusive situations, the following issues should be examined (Giaretto, 1981):

- Is a court order for counseling still in existence?
- Do the family members, particularly the parents, feel they have made sufficient progress in their communication, parenting and self-management skills to need no further regular counseling?
- Does the counselor feel they have made sufficient progress?
- Does the probation officer or supervising social worker feel there has been enough progress to recommend termination of counseling to the court?
- Is a molestation likely to recur? Has the marital and home environment improved?
- Has the offender taken responsibility for his behavior and become aware of the formerly unconscious impulses which preceded the molestation of his child? Is the offender able to control them if they recur?
- Have the feelings and conflicts between family members (mother, daughter, father, siblings) been dealt with openly and completely so that the family environment is nurturing for the child and other family members? (pp. 192-193)

In sexual abuse situations, the author also examines whether the mother has strengthened her relationship with the victim and has been empowered to protect the child.

In all maltreatment situations, the counselor should examine carefully whether the parents will permit the child to have supportive relationships with adults outside the family. If the child has access to a trusted teacher, minister, neighbor, relative or friend to whom the child could turn for help if trouble began again at home, the child will have a higher degree of safety.

In exploring whether parents are ready to end counseling, the counselor may discuss the parents' feelings about returning for counseling in the future. An analogy can be made with preventive health care. One does not just see a doctor when one is dying or needing surgery. One sees a doctor for routine checkups in order to maintain good health. Similarly, parents may wish to return briefly to a counselor when the child enters a new developmental stage such as adolescence which raises new parenting issues; when there is a change in the family's life situation, e.g., divorce, death, unemployment; or when the parents feel under pressure and as if things might go out of control again. The counselor will also want to explore whether the parents will remain hooked up with outside resources which will provide social controls against deviance or support to the parenting role, e.g., parenting classes, social networks, contact with a probation officer, Alcoholics Anonymous, etc.

From Intervention to Prevention

Abusive parents need a variety of resources to help them stop maltreatment and enable them to provide a safer environment for the child. Counseling does not exist in a vacuum; it is, rather, one of a wide range of interventions that help families. Certainly families need help. The dramatic rise of homelessness among families is a result of preexisting multiple life stresses and creates additional, nearly unbearable stress. When industries face massive layoffs, rates of maltreatment climb in concert with the rates of unemployment. The striking increase of young vulnerable females as single adolescent parents is yet another cause for grave concern in the last years of the Eighties. Child pornography and rings of pedophiles threaten and victimize children. Cutbacks in social programs leave families with diminishing resources.

Counselors can help their communities and their profession to keep the needs of children in the forefront of a helping perspective. Children will be healed and protected as families are helped. Counselors can be instrumental in helping communities assess needs of families and children, and in advocating for the implementation of programs which will support the parenting role in the difficult years which lie ahead. The best way to help a child is not through counseling, but through strengthening the family so that maltreatment will not occur.

REFERENCES

American Humane Association. (1967). *Neglecting parents--a study of psychosocial characteristics*. Englewood, CO: Author.

American Humane Association. (1976). *Group work as a part of protective services*. Englewood, CO: Author.

American Humane Association. (1978). *The fundamentals of child protection*. Englewood, CO: Author.

American Humane Association. (1983). *Annual report, 1981: Highlights of official child neglect and abuse reporting*. Denver, CO: Author.

American Humane Association. (1986, October 29). *Reports of child abuse and neglect continue to increase in 1985* (News release). Denver, CO: Author.

Anderson, J., & Simonitch, B. (1981). Reactive depression in youths experiencing emancipation. *Child Welfare*, *IX*(6), 383-390.

Beezley, P., Martin, H., & Alexander, H. (1976). Comprehensive family oriented therapy. In R. Helfer & C. H. Kempe (Eds.), *Child abuse and neglect: The family and the community* (pp. 169-174). Cambridge, MA: Ballinger.

Belcher, V. (1985). History need not repeat itself: Make children aware of child abuse through literature. *School Counselor*, *31*(1), 44-48.

Bender, B. (1976). Self chosen victims: Scapegoating behavior sequential to battering. *Child Welfare*, *LV*(6), 417-422.

Besharov, D. (1983). *Liability issues in child welfare work*. Washington, DC: American Bar Association.

Bowlby, J. (1973). *Attachment and loss* (Vol. II). New York: Basic Books.

Brandt, R., & Tisza, V. (1979). The sexually misused child. *American Journal of Orthopsychiatry*, (1), 80-90.

Brody, V. (1978). Developmental play: A relationship-focused program for children. *Child Welfare*, *LVII*(9), 591-599.

Burch, C. (1980). Puppet play in a thirteen year old boy: Remembering, repeating, and working through. *Clinical Social Work Journal*, *8*(2), 79-89.

Clifford, M., & Cross, T. (1980). Group therapy for disturbed boys. *Child Welfare*, *LIX*(9), 560-565.

Cohn, A. (1979, November). Effective treatment of child abuse and neglect. *Social Work*, pp. 513-519.

Compton, B., & Galaway B. (1979). Social work processes (2nd ed.). Homewood, IL: Dorsey.

Conger, R. (1982). Behavioral interventions for child abuse. The Behavior Therapist, 5(2), 49-53.

Corey, G., & Corey, M. (1982). Groups: Process and practice. Monterey, CA: Brooks/Cole.

Delson, N., & Clark, M. (1981). Group therapy with sexually molested children. Child Welfare, LX(3), 175-183.

Denser-Gerber, J. (1980). Child prostitution and child pornography: Medical, legal and societal aspects of the commercial exploitation of children. In Sexual abuse of children: Selected readings (pp. 77-79). Washington, DC: National Center on Child Abuse and Neglect, Children's Bureau.

DeYoung, M. (1982). Self injurious behavior in incest victims: A research note. Child Welfare, LXI(8), 577-584.

Dixon, J., & Jenkins, J. O. (1981). Incestuous child sexual abuse: A review of treatment strategies. Clinical Psychology Review, (1), 211-222.

Dreyer, S. S. (1977). The Bookfinder: A guide to children's literature about needs and problems of youth aged 2-15. Circle Pines, MN: American Guidance Service, Inc.

Eaddy, V. B., & Gentry, C. (1981, Winter). Play with a purpose: Interviewing abused or neglected children. Public Welfare, pp. 43-47.

Elmer, E. (1977). Fragile families, troubled children: The aftermath of infant trauma. Pittsburgh, PA: University of Pittsburgh Press.

Elmer, E., & Martin, J. (1986). Adult outcomes of childhood abuse (Final Report). Pittsburgh, PA: Pittsburgh Child Guidance Foundation.

Elmer, E., & Taylor-Brown, S. (1985). Child abuse/neglect/sexual abuse. Washington, DC: U.S. Department of Health and Human Services, Maternal and Child Health.

Faller, K. (Ed.). (1981). Social work with abused and neglected children. New York: Free Press.

Finkelhor, D. (1979). Sexually victimized children. New York: The Free Press.

Finkelhor, D. (1986). A sourcebook on child sexual abuse. Beverly Hills, CA: Sage.

Finkelhor, D., & Browne, A. (1986). Initial and long term effects: A conceptual framework. In D. Finkelhor (Ed.), A sourcebook on child sexual abuse (pp. 180-198). Beverly Hills, CA: Sage.

Freeman, L. (1982). It's my body. Seattle, WA: Parenting Press.

Garbarino, J. (1979). Defining emotional maltreatment: The message is the meaning. Unpublished manuscript.

Garbarino, J. (1983). What we know about child maltreatment. Children and Youth Services Review, 5(1), .

Garbarino, J., & Garbarino, A. (1982). Maltreatment of adolescents. Chicago: National Committee for Prevention of Child Abuse.

Giaretto, H. (1981). A comprehensive child sexual abuse treatment program. In P. B. Mrazek & C. H. Kempe (Eds.), Sexually abused children and their families (pp. 179-198). New York: Pergamon.

Gil, E. (1979). Prevention of abuse and neglect of children in out of home care. San Francisco: Child Abuse Council.

Giovannoni, J., & Becerra, R. (1979). Defining child abuse. New York: Free Press.

Goldberg, G. (1975). Breaking the communication barrier: The initial interview with an abusing parent. Child Welfare, LIV(4), 274-282.

Groth, N. (Ed.). (1982). Sexual victimization of males: Offenses, offenders, and victims. New York: Plenum.

Gruber, K. (1981). The child victim's role in sexual assault. Child Welfare, LX(5), 305-311.

Hartman, A. (1978). Diagrammatic assessment of family relationships. Social Casework, 59, 465-476.

Hartman, A., & Laird, J. (1983). Family centered social work practice. New York: Free Press.

Helfer, R. (1975). Child abuse and neglect: The diagnostic process and treatment program (OHD 75-69). Washington, DC: U.S. Department of Health and Human Services.

Helfer, R., & Kempe, C. H. (1976). Child abuse and neglect: The family and the community. Cambridge, MA: Ballinger.

Helfer, R., McKinney, J. P., & Kempe, R. (1976). Arresting or freezing the developmental process. In R. Helfer & C. H. Kempe, (Eds.), Child abuse and neglect: The family and community (pp. 65-73). Cambridge, MA: Ballinger.

Holder, W., & Mohr, C. (1981). Helping in child protective services. Englewood, CO: American Humane Association.

Holder, W., & Schene, P. (1981). Understanding child abuse and neglect. Englewood, CO: American Humane Association.

Husain, S., & Vandiver, T. (1984). Suicide in children and adolescents. New York: Spectrum.

Irwin, E. (1986). Drama therapy in diagnosis and treatment. Child Welfare, LXV(4), 347-357.

Isaacs, C. (1982). Treatment of child abuse: A review of behavioral interventions. Journal of Applied Behavioral Analysis, 15(2), 273-294.

James, M., & Jongeward, D. (1976). Born to win: Transactional analysis with Gestalt experiments. Reading, MA: Addison Wesley.

Justice, B., & Justice, R. (1976). The abusing family. New York: Human Sciences.

Justice, B., & Justice, R. (1979). The broken taboo: Sex in the family. New York: Human Sciences.

Kinard, E. M. (1982). Experiencing child abuse: Effects on emotional adjustment. American Journal of Orthopsychiatry, 52(11), 82-91.

Kraizer, S. (1985). The safe child. New York: Dell.

Lenett, R., & Crane, B. (1985). It's OK to say no: A parent-child manual for the protection of children. New York: St. Martin's Press.

Lero, D., & de Rijcke-Lollis, S. (1980). Early childhood educators: Their contact with abused and neglected children. Child Welfare, LIX(3), 169-178.

Littner, N. (1960). The child's need to repeat his past: Some implications for placement. Social Service Review, 34(2), 128-148.

Malyon, A. (1981). The homosexual adolescent: Developmental issues and social bias. Child Welfare, LX(5), 321-330.

Martin, H. P. (1976). The abused child. Cambridge, MA: Ballinger.

Mayer, A. (1983). Incest: A treatment manual for therapy with victims, spouses and offenders. Holmes Beach, FL: Learning Publications.

Mayhall, P., & Norgard, K. E. (1983). Child abuse and neglect: Sharing responsibility. New York: John Wiley and Sons.

McCarty, L. (1986). Mother child incest: Characteristics of the offender. Child Welfare, LXV(5), 447-458.

McFadden, E. J. (1978). Fostering the battered and abused child. Ypsilanti, MI: Eastern Michigan University.

McFadden, E. J. (1983). Emotional development: The foster child's identity. Ypsilanti, MI: Eastern Michigan University.

McFadden, E. J. (1984). Preventing abuse in foster care. Ypsilanti, MI: Eastern Michigan University.

McFadden, E. J. (1986a). Fostering the child who has been sexually abused. Ypsilanti, MI: Eastern Michigan University.

McFadden, E. J. (1986b). Helping the abused child through play. In J. McKee (Ed.), Play: Working partner of growth (pp. 73-79). Wheaton, MD: Association for Childhood Education International.

McFadden, E. J., & Ryan, P. (1986, August). Characteristics of the vulnerable child. Paper presented at the International Conference on Child Abuse and Neglect, Sydney, Australia.

McKee, J. (1986). Play: Working partner of growth. Wheaton, MD: Association for Childhood Education International.

Miller, F. (1982). Protection of children in foster family care. New York: Vera Institute of Justice.

Minuchin, S. (1978). Families and family therapy. Cambridge, MA: Harrod Press.

Morgan, M. (1984). My feelings. Eugene, OR: Migima Designs.

Mrazek, P. B., & Kempe, C. H. (1981). Sexually abused children and their families. New York: Pergamon.

Nasjleti, M. (1980). Suffering in silence: The male incest victim. Child Welfare, LIX(5), 269-275.

National Center on Child Abuse and Neglect. (1975). The community team, an approach to case management and prevention. Washington, DC: U.S. Department of Health, Education and Welfare.

National Center on Child Abuse and Neglect. (1979). Child abuse and neglect state reporting laws. Washington, DC: Children's Bureau.

National Center on Child Abuse and Neglect. (1981). Selected readings on adolescent maltreatment. Washington, DC: U.S. Department of Health and Human Services.

Nomellini, S., & Katz, R. (1983). Effects of anger control training on abusive parents. Cognitive Therapy and Research, 7(1), 57-68.

Otto, M., & Brown, R. (1985, April). Group treatment for abusive parents. Paper presented at the Annual Convention of the American Association for Counseling and Development, New York.

Parish, R. (1985). Developmental milestones in abused children and their improvement with a family oriented approach to the treatment of child abuse. Child Abuse and Neglect, 9, 245-250.

Phillips, N., Gorman, K., & Bodenheimer, N. (1981). High-risk infants and mothers in groups. *Social Work, 26*(3), 157-161.

Pines, M. (1979, October). Superkids. *Psychology Today*, pp. 53-63.

Powell, G. J. (1983). *The psychosocial development of minority children*. New York: Brunner/Mazel.

Rindfleisch, N., & Rabb, J. (1982). *Dilemmas in planning for the protection of children and youth in residential facilities*. Columbus, OH: Ohio State University, College of Social Work.

Ryan, P. (1983). Survey of the states. *Impact*. Ypsilanti, MI: Eastern Michigan University.

Ryan, P. (1984). *Fostering discipline*. Ypsilanti, MI: Eastern Michigan University.

Salter, A., Richardson, C., & Kairys, S. (1985). Caring for abused preschoolers. *Child Welfare, LXIV*(4), 343-356.

Salter, A., Richardson, C., & Martin, P. (1985). Treating abusive parents. *Child Welfare, LXIV*(4), 327-341.

Saltzman, A. (1986). Reporting child abusers and protecting substance abusers. *Social Work, 31*(6), 474-476.

Steele, B. (1976). *Working with abusive parents from a psychiatric point of view* (OHD76-30070). Washington, DC: U.S. Department of Health, Education and Welfare.

Steele, B. (1986). Notes on the lasting effect of early child abuse throughout the life cycle. *Child Abuse and Neglect, 10*, 281-291.

Stehno, S. (1982). Differential treatment of minority children in systems. *Social Work, 27*(1), 44-52.

Stovall, B. (1981). *Child sexual abuse*. Ypsilanti, MI: Eastern Michigan University.

Stovall, B. (1984). Child sexual abuse in foster care. In E. J. McFadden (Ed.), *Preventing abuse in foster care* (pp. 117-143). Ypsilanti, MI: Eastern Michigan University.

Strauss, M., & Gelles, R. (1980). *Behind closed doors: Violence in the American family*. New York: Anchor/Doubleday.

Thayer, L. (1976). *50 strategies for experiential learning*. San Diego: University Associates.

Thayer, L. (1981). *50 strategies for experiential learning: Book two*. San Diego: University Associates.

Thayer, L., & Beeler, K. (1977). *Affective education*. Ypsilanti, MI: Eastern Michigan University.

Timberlake, E. (1979). Aggression and depression among abused and non-abused children in foster care. *Children and Youth Services Review, 1*(3), 279-291.

Timmons-Mitchell, J. (1986). Containing aggressive acting out in abused children. *Child Welfare, LXV*(5), 459-468.

Tower, C. (1984). *Child abuse and neglect: A teacher's handout for detection, reporting and classroom management*. Washington, DC: National Education Association.

Trainor, C. (1983). *The dilemma of child neglect*. Denver, CO: American Humane Association.

Veresh, C. (1978). *Guiding the sexual development of your foster child*. Ypsilanti, MI: Eastern Michigan University.

Wasserman, S., & Rosenfeld, A. (1986). Decision making in child abuse and neglect. *Child Welfare, LXV*(6), 515-529.

Watkins, H., & Bradbard, M. (1982). Child maltreatment: An overview with suggestions for intervention and research. *Family Relations, 31*(6), 323-332.

Wattenberg, E. (1985). In a different right: A feminist perspective on the role of mothers in father-daughter incest. *Child Welfare, LXIV*(3), 203-212.

Weinbach, R., & Curtiss, C. (1986). Making child abuse victims aware of their victimization: A treatment issue. *Child Welfare, LXV*(4), 337-346.

Williams, J. (1980). *Red flag green flag people*. Fargo, ND: Rape and Abuse Crisis Center of Fargo--Moorhead.

Wohl, A., & Kaufman, B. (1985). *Silent screams and hidden cries: An interpretation of artwork by children from violent homes*. New York: Brunner Mazel.

Wooden, K. (1985). *Child lures: A guide to prevent abduction*. St. Louis, MO: Ralston Purina.

Ziefert, M. (1982). *Adolescent abuse and neglect*. Ypsilanti, MI: Eastern Michigan University.

Ziefert, M. (1984). The abused adolescent. In E. J. McFadden, *Preventing abuse in foster care* (pp. 89-115). Ypsilanti, MI: Eastern Michigan University.

Ziefert, M., & Faller, K. (1981). The interdisciplinary team and the community. In K. Faller (Ed.), *Social work with abused and neglected children* (pp. 173-176). New York: Free Press.

RESOURCES FOR COUNSELORS

ERIC Clearinghouse on Counseling and Personnel Services
2108 School of Education
The University of Michigan
Ann Arbor, Michigan 48109-1259
(313) 764-9492

Institute for the Study of Children and Families
Eastern Michigan University
Ypsilanti, Michigan 48197
(313) 487-0372

National Association of Social Workers
7981 Eastern Avenue
Silver Springs, Maryland 20910
(301) 565-0333

National Center on Child Abuse and Neglect
P.O. Box 1182
Washington, DC 20013
(202) 245-2840

National Child Abuse Clinical Resource Center
Dr. Richard Krugman, Director
Kempe Center
University of Colorado
1205 Oneida Street
Denver, CO 80220
(303) 321-3963

National Committee for the Prevention of Child Abuse
332 S. Michigan Avenue, Suite 1250
Chicago, IL 60604
(312) 663-3520

National Legal Resource Center for Child Welfare Services
Robert Horowitz, Director
American Bar Association
1800 M Street, NW, Suite S-200
Washington, DC 20036
(202) 331-2250

National Resource Center for Child Abuse and Neglect
Patricia Schene, Director
American Humane Association
9725 East Hampden Avenue
Denver, CO 80231
(303) 695-0811

National Resource Center for Family Based Services
Janet Hutchinson, Director
University of Iowa
N240A Oakdale Hall
Iowa City, IA 52242
(319) 353-5076

National Resource Center for Foster and Residential Care
Ronald K. Green, Director
Child Welfare Institute
P.O. Box 77364
Station C
Atlanta, Georgia 30357
(404) 876-1934

National Resource Center for Youth Services
James M. Walker, Director
University of Oklahoma
440 South Houston, Suite 751
Tulsa, Oklahoma 74127
(918) 581-2986